IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

JOHN B. CARRIE G., JOSHUA M., MEAGAN A. and ERICA A., by their next friend, L.A.; DUSTN P. by his next friend, LINDA C. BAYLIS. By her next friend, C.W.; JAMES D. by his next friend, Susan H.; ELSIE H. by her next friend, Stacy Miller; JULIAN C. by his next friend, Shawn C.; TROY D. by his next friend, T.W.; RAY M. by his next friend, P.D.; ROSCOE W. by his next friend, K.B.; JACOB R. by his next friend, Kim R.; JUSTIN S. by his next friend, Diane P.; ESTEL W. by his next friend, E.D.; individually and on behalf of all others similarly situated,	)
Plaintiffs,	)
v.	)NO. 3-98-0168)Judge Nixon
NANCY MENKE, Commissioner, Tennessee Department of Health; THERESA CLARKE, Assistant Commissioner Bureau of TennCare; and GEORGE HATTAWAY, Commissioner Tennessee Department of Children's Services	)
Defendants.	)

JULY 2000 SEMI-ANNUAL PROGRESS REPORT

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regarding their compliance with the terms of this order. Such reports are to be filed on July 31st and January 31st of each year. Said reports "shall contain information, validated by the applicable audit and testing procedures outlined herein, which accurately and fully reflect the status of the State's compliance with each of the applicable requirements of this order..."

Attached to this notice is a copy of the Semi-Annual Progress Report for the period ending January 31, 2000. This Report contains the following components:

1. Overview of activities during report period
2. Attachment A: Interagency Agreement (Draft)
3. Attachment B: Hearing and Vision and Behavioral and Developmental Screening Guidelines
4. Attachment C: EPSDT Articles
5. Attachment D: EPSDT Training Dates
6. Attachment E: HCFA Report 416 and Progress Towards EPSDT Targets
7. Attachment F: Summaries of Outreach Efforts for Each TennCare Plan
8. Attachment G: Report of EPSDT Screenings for Children in Custody
9. Attachment H: BHO Case Management Report
10. Attachment I: Barriers and Interventions for BHO Case Management
11. Attachment J: BHO Case Management Report
12. Attachment K: EPSDT Remedial Plan for Children in DCS Custody
13. Attachment L: ETSU Study, "An Evaluation of Health Care Services in the Pediatric TennCare Population."

Pursuant to paragraph 104 of the Consent Decree, this semi-annual report is being provided to plaintiffs' local counsel.

STATE OF TENNESSEE
BUREAU OF TENNCARE
DEPARTMENT OF FINANCE AND ADMINISTRATION
729 CHURCH STREET
NASHVILLE, TENNESSEE 37247-6501

TO: Linda Ross
Office of the Attorney General

FROM: Kasi Tiller
Bureau of TennCare

DATE: August 2, 2000

RE: Review of Appeals Report for the Semi-annual EPSDT Progress Report

Attached please find the January –June 2000 EPSDT Appeals Report. At the time the semi-annual progress report was submitted to the Courts this report was not completed and we stated that it would be sent under separate cover. Please handle accordingly. Thanks

cc: Susie Baird
Denise Neely

Bureau of TennCare is currently finalizing a grant to be awarded to the NHCHC so that direct training and technical support activities to facilitate TennCare enrollment of homeless children will continue for the 2000-2001 fiscal year.

- **EPSDT Task Force of Davidson County**. The Davidson County EPSDT Task Force was established last summer and is represented by members of the health care community representing Davidson County including: MCOs, BHOs, advocacy organizations, the Metropolitan Davidson County Health Department and the Bureau of TennCare. The task force has come together to network with related agencies and to draw upon the resources and energy of stakeholder agencies to facilitate and strengthen efforts to build awareness about EPSDT in Davidson County.

- **Interagency Agreement**. An interagency agreement between the Departments of Education (DOE), Mental Health and Retardation (DMHMR), Children's Services (DCS), and Finance and Administration (TDFA) is being finalized. A draft of the agreement can be found in Attachment A. The agreement facilitates the provision and coordination of services for infants, toddlers, children, youth and adolescents who are eligible under the Individuals with Disabilities Education Act (IDEA). The agreement also formalizes policies, procedures, and fiscal responsibilities for each department and will be very helpful in resolving problems and making sure that each department is aware of services offered by other departments and how to access services for children.

- **Dental Study.** The Quality Oversight Unit requested the External Quality Review Organization (EQRO) to conduct a dental study on children three years to six years old from the same sample of records used in the EPSDT medical record review. The dental study will identify all dental services provided to the sample of children and part of the study will determine if the children in the study who received a dental referral actually received a dental service. Data collection is underway at this time.

Accomplishments during the Reporting Period

1. **EPSDT Screening Guidelines Committee**. *(Paragraph 44)* As a result of the EPSDT Consent Decree, the Bureau of TennCare established an EPSDT Screening Guidelines Committee. The committee was charged with recommending screening guidelines for providers to help insure that children in need of further hearing and vision and/or behavioral and developmental assessments are identified through the periodic screens. Membership of this committee consisted of EPSDT providers, MCO/BHO medical directors, researchers, practitioners, medical educators and vision, hearing, developmental and behavioral specialists. Members were either nominated by their respective professional organizations—the Tennessee Academy of Family Physicians, the Tennessee Pediatric Society, the Tennessee Medical Association, and the Tennessee Nursing Association, or were recommended by the plaintiffs' attorneys.

The state has not met the target EPSDT screening requirements outlined in the Consent Decree, however, TennCare shall be in compliance with the screening obligations under the law if children who have not received screenings have been the subject of outreach efforts reasonably calculated to ensure their participation. Last fall the Quality Oversight Unit completed an extensive survey of the MCO's outreach and informing activities. A check sheet that listed all the required components of an outreach and informing program was sent to each MCO with a letter requesting that the check sheet be completed and documentation to support the activities submitted to the Bureau. The internal tracking system for each MCO was also reviewed to determine if pending due dates and past due dates for preventive services could be identified for each member.

A spreadsheet was developed that included each element of outreach and informing activities to provide a comprehensive overview of each MCO program. In addition, the MCOs submitted member newsletters, flyers, brochures, and literature from community events. Summaries of each TennCare plan's EPSDT outreach and informing strategies and the spreadsheet can be found in Attachment F.

The External Quality Review Organization (EQRO) continues to monitor MCO activities related to EPSDT services as a part of the annual surveys. The results of the annual surveys are being finalized and will be provided in the next semi-annual progress report.

3. **Summary of EPSDT screens for children in DCS custody**. *(Paragraph 52)* DCS continues to track EPSDT screenings for children in custody. The most recent report issued (See Attachment G.) reports data as of March 31, 2000, and indicates that 75% of children in custody have received a screening and 71% have received a dental screening.

During the months of October and November 1999, DCS converted data from their old tracking system into the new TNKids database. DCS' Data Unit has worked to update and "clean up" the data from this conversion process and has worked hard to develop data reporting that would be formatted in a manner that will be easily understood. In June 2000, DCS developed a report that indicates which children in each region of the state have not received an EPSDT screening. This new report will allow the DCS to follow up on all screenings so that they will be adequately documented in the TNKids database.

When BHO services are denied, which may result in a child entering state's custody, DCS assists those families in filing an appeal. Since the filing of the Remedial Plan for Children in Custody, DCS is also referring cases where children are at risk of entering custody while awaiting the results of an appeal to the Remedial Plan Implementation Team. The Implementation Team serves as an ombudsman for children and families in crisis to assist them in accessing needed behavioral health services. DCS is currently educating their regional Health Units on the EPSDT Remedial Plan for Children in Custody.

Attachment J demonstrates improvement for those consumers who accepted a referral for case management but had no encounter. The period July 1999 through September 1999 revealed a percentage of consumers (Premier/TBH) without encounters of 21.54%. Since that time, there has been a decreasing trend in the percentage of consumers (Premier/TBH) without encounters to 9.56% for the period February 2000 through April 2000.

5. **Remedial Plan for Children in the Department of Children's Services' Custody.** *(Paragraphs 88-92)* Pursuant to the EPSDT Consent Decree the State and the plaintiffs' attorneys negotiated a mutually acceptable remedial plan for assuring adequate medical and behavioral services for children in DCS custody. Consultant, Paul DeMuro, facilitated the process and Health Commissioner, Dr. Fredia Wadley, has taken on the task of spearheading the current plan. (See Attachment K) On December 11, 1998, the State filed a proposed plan as required by the Consent Decree. Thereafter, the parties attempted to develop jointly a plan to be filed with the Court for approval. Negotiations broke down and the State filed another proposed plan on February 15, 2000, which superceded the earlier plan. During the following months, the State and the plaintiffs' attorneys were able to resolve their remaining differences and have agreed to the terms of the attached plan, which was filed on May 11, 2000, and was signed and approved by Judge John Nixon of the United States District Court on May 16, 2000. The attached plan supercedes the previous plan submitted to the Court on February 15, 2000. The plan calls for the development of a Best Practice Network of providers composed of primary care physicians, behavioral health providers, dentists, and children's Centers of Excellence (tertiary pediatric centers). The primary care Best Practice Providers are those physicians who (1) are willing to provide primary care to children in custody, (2) are willing to coordinate care between themselves and other health providers, and (3) will work with case managers and care givers of the Department of Children's Services to assure that children receive the services they need.

   In return for their additional efforts in caring for these children, participating primary care providers will receive enhanced financial benefits, free training on problems commonly seen in this population including Best Practice Guidelines, and a mechanism to arrange appointments and consultations with the Centers of Excellence.

   An Implementation Team, including a pediatrician and a child psychiatrist will be working with private providers to resolve any problems that might arise with the implementation of this plan. A Children with Special Health Needs Steering Panel has been organized that will direct a needs assessment and the development of a data system, monitor the progress of the plan and make recommendations for improvement. This panel has six practicing pediatricians from across the state as well as five pediatric specialists from the Centers of Excellence.

   Progress to date:

   - The Implementation Team has been formed and is functioning.

- Areas needing improvement included the rate at which children are seen for EPSDT well child and preventive services, access to dental care, and increased parent/caregiver education regarding EPSDT benefits and services.

7. **Network Adequacy**. *(Paragraph 43)* In June of 1999, the Provider Networks Section implemented a new survey in order to assure network adequacy. Each MCO and BHO submits to TennCare a listing of all providers with whom they are contracted to provide services. The Provider Network staff conducts on site reviews to verify that contracts have been executed properly. When a properly executed contract is identified, the Provider Network staff calls provider offices to verify contract status and they also verify information such as the ages of patients the provider is willing to service, whether the provider is accepting new patients, whether the provider offers prenatal care, accepts presumptive eligibles and inquires about the length of time it takes to obtain an appointment for routine services. From data collected, GeoAccess mapping analyses and enrollee to provider ratios are calculated by Community Service Area.

   In February 2000, the Provider Network staff conducted on site reviews at BlueCare. A telephone survey was completed and GeoAccess mapping analyses of provider to enrollee ratios was calculated. No deficiencies were identified as a result of the BlueCare on site contract review.

   On site reviews were conducted with both BHOs on May 26, 2000. The Provider Network staff is currently conducting a telephone survey to verify BHO provider participation data.

   Routine monthly updates are received from the MCOs/BHOs in order to make the appropriate additions, deletions and/or changes to provider files. In July of this year the Provider Network Section implemented a new system of obtaining monthly provider information from the MCOs/BHOs. This new process will prevent repetitious data submissions and create a more comprehensive, accurate database with a more current listing of providers.

8. **Compliance with HCFA access standards** *(Paragraph 61ii)* Quarterly, the Provider Network Section performs a GeoAccess mapping analyses of the MCO's inpatient, primary care, dental and prenatal provider networks as well as the BHO's outpatient, inpatient, and 24-hour residential mental health provider networks.

   Additionally, the Provider Network staff performs an analysis of the MCOs Pediatric Network to assure that all provider networks are in compliance with access standards. One MCO had deficiencies in their dental network. A request for the retention of a withhold has been submitted to TennCare's Contract and Compliance Unit and is currently under review.

9. **Review of Appeals**. *(Paragraph 101)* This information will be submitted under separate cover.

Attachment A

Interagency Agreement (DRAFT)

Table of Contents

Article One

Parties to Agreement

This Interagency Agreement (Agreement) is entered into by the Tennessee Department of Education (DOE), the Tennessee Department of Children's Services (DCS), the Tennessee Department of Finance and Administration (TDFA), the Tennessee Department of Health (DOH), the Tennessee Department of Human Services (DHS), the Tennessee Department of Mental Health and Mental Retardation (TDMHMR), and the Tennessee Division of Mental Retardation Services (DMRS). This includes all offices, divisions, bureaus, units and programs referred to in this Agreement for which each Department provides oversight.

Article Two

Purpose

This Interagency Agreement is intended to fulfill the requirements of Part B and Part C of the Individuals with Disabilities Education Act, 20 U.S.C. §1400 *et seq.* (IDEA). The purpose of this Agreement is to identify and define the financial responsibilities of the Parties to this Agreement and to facilitate the provision and coordination of services for all infants, toddlers, children, youth and adolescents who are IDEA eligible. This Agreement formalizes policies, procedures, and fiscal responsibilities of the Parties. For purposes of this Interagency Agreement, the term "child with a disability" shall always be defined according to 34 CFR §300.7(a) unless otherwise specified.

Article Three

Definitions

For purposes of this Interagency Agreement,

1. **"Assessment"** for Part B purposes, means the collection and integration of information to determine a student's current level of emotional, behavioral, academic, and intellectual functioning, educational needs, and strategies for remediation to promote effective treatment. *Special Education Dictionary.* For Part C purposes, it means the ongoing procedures used by qualified personnel throughout the period of a child's eligibility under Part C to identify: (a) the child's unique strengths and needs and the services appropriate to meet those needs; and (b) the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability. *34 CFR §303.322(b)(2).*

2. **"Behavioral health organization" (BHO)** means a type of managed care organization approved by TennCare or by a designee of TennCare to deliver mental health and substance abuse services to TennCare enrollees. *Tenn. Rule 1200-13-12-.01(2).*

3. **"Child Find"** means the collective name for Tennessee's policies and procedures, coordinated with all other major efforts conducted by Participating Agencies, designed and implemented to ensure that all children with disabilities (including children with disabilities

12. **"Emergency medical condition"** for TennCare purposes, means a medical condition that manifests itself by symptoms of sufficient severity (including severe pain) that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the person's health (or, with respect to a pregnant woman, potentially her unborn child's) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. *Tenn. Rule 1200-13-12-.01(12).*

13. **"Evaluation"** for the purposes of Part B, means procedures used to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs. *34 CFR §300.500(b)(2).* For Part C purposes, it means the procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility, consistent with the definition of "infants and toddlers with disabilities" in Tennessee, including determining the status of the child in each of the following developmental areas: (a) cognitive development; (b) physical development, including vision and hearing; (c) communication development; (d) social-emotional development; and (e) adaptive skills. *34 CFR §303.322(b)(1).*

14. **"Family Educational Rights and Privacy Act"** (FERPA) means the collective name for federal legislation prohibiting educational agencies or institutions from releasing education records of students unless consistent with the terms of the Act. *20 U.S.C. § 1232g.*

15. **"Foster care"** means the temporary placement of a child in the custody of DCS or any agency, institution, or home, whether public or private, for care outside the home of a parent or relative (by blood or marriage) of the child, whether such placement is by court order, voluntary placement agreement, surrender of parental rights or otherwise. Foster care shall cease at such time as the child is placed with an individual for the purpose of the child's adoption by the individual or at such time as a petition to adopt is filed, whichever occurs first, or at such time as the child is returned to or placed in the care of a parent or relative. *TCA §37-2-402(5).*

16. **"Foster home"** means a private home which is approved by DCS or other licensed child-placing agency and provides full time care for up to six (6) children at one time. This maximum includes birth, adopted or foster children. *DCS Glossary p. 14.*

17. **"Free appropriate public education"** (FAPE) means regular and special education and related services which:

(a) Are provided at public expense, under public supervision and direction, and without charge to the parent;

(b) Meet the standards established by state law, including the requirements of IDEA Part B and the *Rules, Regulations and Minimum Standards for the Governance of Tennessee Public Schools,* issued by DOE;

(c) Include preschool, elementary school, and secondary school (including appropriate vocational, career or work experience education) and

(d) Are provided in conformity with an individualized education program (IEP). *34 CFR §300.13.*

18. **"*Grier* revised Consent Decree"** means the consent decree *Grier v. Wadley,* U.S. Dist. (M.D. Tenn.) Civil Action No. 79-3107 entered January 25, 2000.

26. **"Intra-agency dispute"** means the inability of divisions, offices, bureaus, units or programs within a department or agency to agree as to which is responsible for coordinating services; providing appropriate services; paying for appropriate services or any other matter related to the department's or agency's statutory responsibilities.

27. **"Interagency dispute"** means any disagreement between two or more Participating Agencies concerning the responsibility for coordination of services, provision of appropriate services, payment for appropriate services or any other matter related to this Agreement for an eligible child under IDEA Part B and C.

28. **"*John B.* Consent Decree"** means the consent decree *John B. v. Menke*, U.S. Dist. (M.D. Tenn.) Civil Action No. 0168, entered March 11, 1998.

29. **"Least restrictive environment"** means to the maximum extent appropriate, an environment where children with disabilities, including children in public or private institutions or other care facilities, are educated with children who are nondisabled. *34 CFR §300.550 (b)(1).*

30. **"Local educational agency"** (LEA) means a public board of education or other public authority legally constituted within Tennessee for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of Tennessee, or for a combination of school districts or counties that are recognized in Tennessee as an administrative agency for its public elementary or secondary schools. *34 CFR §300.18(a).*

31. **"Managed Care Organization"** (MCO) means an appropriately licensed HMO approved by the TDFA/Bureau of TennCare as capable of providing medical services in the TennCare program. *Tenn. Rule 1200-13-12-.01(24).*

32. **"Medical assistance"** as used in the TennCare Rules and for purposes of this Agreement, means care, services, drugs, equipment, and supplies prescribed as medically necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, or interfere with or threaten some significant impairment and which are furnished in accordance with Title XIX of the Social Security Act (Medicaid) and T.C.A. §71-5-101 *et seq.* (Welfare-Programs and Services for Poor Persons-Medical Assistance). Such care, services, drugs, and supplies shall include services of qualified practitioners licensed under the laws of the State of Tennessee. *TCA §71-5-103(5).*

33. **"Medical services"** means services provided by a licensed physician to fulfill the requirements of IDEA in order to determine a child's medically related disability that results in the child's need for special education and related services. *34 CFR §300.24(b)(4).*

34. **"Medically necessary"** means services or supplies provided by an institution, physician, or other provider which are required to identify or treat a person's illness or injury and which are:

(a) Consistent with the symptoms or diagnosis and treatment of the person's condition, disease, ailment, or injury; and
(b) Appropriate with regard to standards of good medical practice; and
(c) Not solely for the convenience of a person, physician, institution or other provider; and

41. **"Primary care physician"** (PCP) means physicians who have limited their practice of medicine to general practice, or physicians who are Board Certified or Board Eligible in any of the following: Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice. *Tenn. Rule 1200-13-12-.08(10)(b)(1)(I).*

42. **"Primary referral sources"** means hospitals (including prenatal and postnatal care facilities), physicians, parents, day care programs, local educational agencies, public health facilities, other social services agencies, and other health care providers. *34 CFR §303.321(d)(3).*

43. **"Regional Mental Health Institute"** (RMHI) means a mental health facility or institution of the state of Tennessee over which TDMHMR has exclusive jurisdiction and control. *TCA §4-3-1603(a).*

44. **"Related services"** means transportation and such developmental, corrective, and other supportive services that are required to assist a child with a disability to benefit from special education. It includes speech-language pathology and audiology services; psychological services; physical and occupational therapy; recreation, including therapeutic recreation; early identification and assessment of disabilities in children; counseling services, including rehabilitation counseling; orientation and mobility services; and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training. *34 CFR §300.24(a).*

45. **"Residential facility"** means a facility that offers twenty-four (24) hour residential care as well as a treatment and habilitation component.

46. **"Runaway house/shelter"** means any house or institution, operated by DCS, giving sanctuary or housing to any person under eighteen (18) years of age who is away from home or the residence of his/her parent without the parent's consent. *TCA §37-2-502(3).*

47. **"School health services"** means services provided in school or at school sponsored events by a qualified school health nurse or other qualified health care professional. *34 CFR §300.24(b)(12).*

48. **"Service coordinator"** means the individual appointed by a public agency or selected by the IFSP team and designated in the IFSP to carry out service coordination activities. Service coordinators shall have demonstrated knowledge and understanding about: eligible children; IDEA Part C; the nature, scope, and availability of services within the early intervention system; the system of payments for early intervention services; and other pertinent information. *34 CFR §303.22.*

49. **"Special education"** means specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability, including (i) instruction conducted in the classroom, in the home, in hospitals, in institutions, and in other settings; and (ii) instruction in physical education. *34 CFR §300.26(a).*

50. **"Surrogate parent"** means a person appointed when a child is a ward of the state or the parent or legal guardian is unable to be located after reasonable efforts by the public agency. For IDEA purposes, the surrogate parent may represent a child in all matters relating to: (a) the

Article Four

IDEA PART B SERVICES

A. Tennessee Department of Education

1. DOE will coordinate the provision of services under this Agreement to ensure that children who are IDEA eligible receive FAPE in the least restrictive environment.

2. The use of an interagency agreement does not alter or diminish the responsibility of DOE to ensure compliance of all public agencies serving children with disabilities with the requirements of IDEA. This will be accomplished through compliance monitoring.

3. Each LEA will file with DOE an annual comprehensive plan for providing special education and related services to children with disabilities who reside within its jurisdiction. DOE will ensure that the comprehensive plan is in compliance with IDEA Part B and all state and federal statutes and regulations. It shall be the responsibility of the LEA or responsible state agency to determine eligibility, provide the appropriate special education and related services, and to fulfill the requirements of IDEA Part B for all children who are IDEA eligible. *34 CFR §300.320(a).* If DOE determines that a LEA or responsible state agency is unable to meet its obligations under IDEA, DOE shall use IDEA Part B funds that would otherwise have been available to a LEA or state agency and provide or cause to be provided special education and related services directly to children who are IDEA eligible formerly served by the LEA or state agency. *34 CFR §300.360(a).*

4. Any state agency or private school shall comply with the Tennessee Department of Education's *Rules, Regulations, and Minimum Standards for the Governance of Tennessee Public Schools* in the establishment of an educational program. Any facility or LEA that serves a child who is IDEA eligible must also meet the standards established by IDEA and TCA §49-10 (Special Education). DOE will monitor all state agencies providing educational programs, and private schools to ensure compliance with applicable federal and state regulations. Each facility will be monitored on a three (3) year cycle. One year prior to being monitored, all agencies or private schools will be provided technical assistance by DOE. DOE shall then conduct an on-site review of the educational program at the facility or school. Once the review is complete, DOE generally issues a report within thirty (30) calendar days. The report shall include commendations, recommendations, and exceptions that need to be corrected to bring the program in compliance with IDEA and all other applicable state and federal laws and regulations. When exceptions are identified, the facility or school shall be required to provide a corrective action plan (CAP) to DOE within thirty (30) calendar day of the receipt of the report. The corrective action plan shall outline steps and timelines for correcting the exceptions. DOE shall review the plan to assure that it is adequate to ameliorate the exceptions and will follow up with an on-site visit to ensure compliance.

5. DOE is responsible for maintaining a database of information provided by the LEAs on children with disabilities known as a census. DOE shall provide census information to the U.S. Department of Education as required by federal law.

education expenditures from the General Purpose School Fund and not IDEA Part B, and/or Preschool Grant funds. The DOE/Division of Special Education shall make the final decision regarding the amount of reimbursement and allotment of funds.

12. DOE, in conjunction with the other Participating Agencies as appropriate, shall provide technical assistance and training to the LEAs as it relates to the billing of other public agencies that are providing services to children who are IDEA eligible and provide any other training and assistance as necessary. For this purpose, DOE will be responsible for coordinating the provision of services with LEAs through the state's Regional Resource Centers to be supported by the Participating Agencies. These Regional Resource Centers will provide technical assistance to LEAs in areas such as evaluation, appeals, best practices, reporting procedures, appropriate provision of special education and related services for individual children, and any other identified areas as needed.

13. DOE shall furnish TennCare/EPSDT providers with criteria and training concerning IDEA requirements. TennCare will train TennCare/EPSDT providers concerning EPSDT requirements. TennCare will ensure that MCOs provide appropriate technical assistance to TennCare providers in billing and the coordination of services for children who are IDEA eligible. This training will be conducted annually and will begin within ninety (90) after this Agreement has become final.

14. Through state statute, Tennessee has extended eligibility for special education and related services to children identified as functionally delayed in accord with *Rules, Regulations, and Minimum Standards for the Governance of Tennessee Public Schools.* Although not entitled to services under IDEA, a child identified as functionally delayed is considered a child with a disability for purposes of this Agreement and shall receive the same services and protections as a child with a disability under IDEA.

B. Local Educational Agency

1. When the local educational agency (LEA) finds or suspects that a child may be eligible for special education and related services under the IDEA, the LEA, with the permission of the parent or legal guardian, shall secure an appropriate evaluation to determine if a child is eligible for special education and related services. If the child is a TennCare enrollee, the LEA, with the permission of the child's parent or legal guardian, may refer the child for an EPSDT screen. *See Article 4 Section C – TennCare.* If appropriate, the child shall be referred for an evaluation to be performed by the child's PCP or if the PCP is not qualified or appropriate to perform an IDEA eligibility evaluation, the PCP will refer the child to a qualified provider. These screens shall be provided by the child's PCP under contract with the MCO. When a LEA suspects that a TennCare enrolled child may have a particular medical or behavioral health problem and the child is up-to-date on his EPSDT screenings, the LEA should refer the child to the child's PCP for an EPSDT interperiodic screen. However, the LEA must complete the evaluation process within the timelines promulgated by DOE in *Rules, Regulations and Minimum Standards for the Governance of Tennessee Public Schools.* This provision does not alter the timeliness requirements for EPSDT screens by which the MCOs are bound.

2. Parents of students who are IDEA eligible and students referred for an IDEA eligibility evaluation will be asked to complete a voluntary form to indicate if the child is receiving

3. TennCare is responsible for providing EPSDT services for all children who are TennCare enrollees. EPSDT services include: (a) periodic well-child screenings in accordance with the recommendations of the American Academy of Pediatrics; (b) medically necessary health and behavioral health diagnostic services; and (c) medically necessary health and behavioral health treatment services. EPSDT treatment services include "such other necessary health care, diagnostic services, treatment and other measures [described in §1396d(a)] . . . to correct or to ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan." *42 USC §1396d(r)(5); John B. Consent Decree at p. 5.* EPSDT services are based on the individual child's medical, developmental, and behavioral health needs. No prior authorization by the MCO is needed for a screen conducted by a PCP, and the MCO will provide all medically necessary covered services regardless of whether or not the need for such services was identified by a provider who received prior authorization or by an in-network provider. *John B. Consent Decree at p. 21.* TennCare (including its contractors, the MCOs and BHOs) cannot impose limitations on EPSDT services other than medical necessity. This means that the state cannot set arbitrary limits of duration, scope, or cost of services under EPSDT. *John B. Consent Decree at p. 33.* The MCOs and BHOs have the discretion to require that their network providers deliver TennCare covered services, as long as the networks are sufficient in size and scope to meet the access standards of the MCO/BHO's contract with the state.

4. Any encounter with a health professional practicing within the scope of his/her practice is an interperiodic screen. Any person such as an educator, parent, or health professional who suspects a health problem may refer a child for an interperiodic screen. An interperiodic screen does not have to include any screening elements required for a periodic screen. No prior MCO authorization is required for an interperiodic screen, and the MCO shall provide all medically necessary covered services identified by the interperiodic screen. *John B. Consent Decree at p. 23.*

5. LEAs, with parental consent, should refer TennCare enrolled children for EPSDT screenings when the child is not up to date on his/her screens. Neither the parent nor TennCare is required to inform the LEA that the child is a TennCare enrollee. The child's MCO will be responsible for identifying whether or not the child's screenings are up-to-date and shall be responsible for providing screenings as needed. The MCO may share this information with the LEA only with parental consent. These screens shall be provided by the child's PCP under contract with the MCO. When a LEA suspects that a TennCare enrolled child may have a particular medical or behavioral health problem and the child is up-to-date on his EPSDT screenings, the LEA should refer the child to the child's PCP for an EPSDT interperiodic screen. The PCP will make recommendations to the MCO/BHO if he/she believes there is a need for additional diagnosis and/or treatment that is medically necessary. *John B. Consent Decree at p. 38.*

6. TennCare will provide all covered medically necessary services, including durable medical equipment, for all children who are TennCare enrollees, regardless of whether or not these children are IDEA eligible. TennCare shall provide transportation to and from appointments for services covered by TennCare when the enrollee does not have access to transportation services. *John B. Consent Decree at pp. 41-2.* TennCare may not disqualify an eligible service for TennCare reimbursement because that service is provided in accord with an IEP. *34 CFR §300.142(b)(1)(i).* MCOs and BHOs have the discretion to require that covered services be delivered by providers in their networks, within the access standards required in their contracts with the state. There is no specific requirement that MCOs and BHOs provide services in the

D. Tennessee Department of Children's Services

1. No child with a disability shall be denied special education and related services in the least restrictive environment because of his/her status as a child in state custody. For the purposes of DCS and this section of the Agreement, least restrictive environment means the placement that is no more restrictive than is necessary to meet the treatment and security needs of the student. *DCS Glossary p. 18.* As governed by IDEA, all educational placements, and special education, and related services decisions remain with the child's IEP Team when the child is placed in state custody.

2. Placement in DCS custody is court ordered due to dependency and neglect, unruliness or delinquency, and is not an educational placement. DCS develops a permanency plan for each child which includes education, behavior, personality, family and testing results. If the child is IDEA eligible or needs to be referred for testing, this will be indicated on the permanency plan.

3. The provision and cost of special education and related services for a child with a disability in DCS custody and living in a foster home shall be provided for in the following manner:

   a. The local LEA, where the child is residing, shall be the LEA for a child living in a foster home. The local LEA shall have primary responsibility for fulfilling the requirements of IDEA. *See Article 4, Section B - LEA.*

   b. DCS shall refer the child to the LEA, where the child is residing, which will evaluate the child for IDEA eligibility. The local LEA shall convene an IEP Team meeting to determine IDEA eligibility and develop and implement an IEP if appropriate. *See Article 4, Section B - LEA.*

   c. A DCS representative shall be present at the IEP Team meeting of a child who is IDEA eligible in DCS custody. However, the DCS representative may not sign the IEP, as a parent. The parent must sign the IEP. If a parent cannot be located, the LEA will appoint a surrogate parent. The surrogate parent, when representing the child's educational interests, shall have the same rights as parents of children who are IDEA eligible.

   d. DCS shall be financially responsible for the room and board of children in foster care.

4. The provision and cost of special education and related services for a child who is IDEA eligible in DCS custody and attending an approved DOE school at a DCS contract facility shall be provided for as follows:

   a. The DCS contract facility shall convene an IEP Team meeting in order to determine eligibility and develop and implement an appropriate IEP. The DCS contract facility provides special education and related services and ensures that a child who is IDEA eligible receives the services in his/her IEP in a reasonable time. The participation of other agencies in a child's IEP Team meeting and the financial responsibility to provide services shall not be altered because a child is attending school in a contract facility. The contract facility may receive reimbursement for services provided from other public agencies, as appropriate. *See Article 4, Section B10 - LEA.*

7. The provision and cost of special education and related services for a child with a disability in DCS custody, living in a DCS residential facility and attending an in-house school shall be provided for in the following manner:

a. DCS may serve as the LEA for children who are in the custody of DCS and reside in DCS residential facilities. *TCA §37-5-119.* DCS, if it is the LEA, shall assume the cost of special education and related services for an IDEA eligible child who resides in a DCS residential facility.

b. In accordance with IDEA, DCS, as the LEA, shall convene an IEP Team meeting to determine eligibility and develop and implement an IEP in accordance with the child's Permanency Plan, if appropriate.

c. DCS, if it is the LEA, will pay for an evaluation to determine if a child in its custody and living in a residential facility may be IDEA eligible.

d. The financial responsibility of other Participating Agencies to provides services in the child's IEP will not be altered because the IDEA eligible child is being educated in a residential facility.

e. DCS shall pay the residential costs for children in DCS custody who need residential treatment.

8. The provision and cost of special education and related services for a child who is IDEA eligible in DCS custody, residing in a Youth Development Center (YDC) shall be paid for in the following manner:

a. DCS shall serve as the LEA for children who are in the custody of DCS and reside in YDC. *TCA §37-5-119.* DCS shall assume the cost of special education and related services for a child who is IDEA eligible who resides in a YDC.

b. In accordance with IDEA, DCS, as the LEA, shall convene an IEP Team meeting to determine eligibility and develop and implement an IEP in accordance with the child's Permanency Plan, if appropriate.

c. DCS will pay for an evaluation to determine if a child in its custody and living in a YDC may be IDEA eligible.

d. The financial responsibility of other Participating Agencies to provides services in the child's IEP will not be altered because the child who is IDEA eligible is being educated in a YDC. *But see Article 4 Section D paragraph 14.* [The issue is being reviewed by the Attorney General's Office and may change before the Agreement is sent to the Commissioners.]

e. DCS shall pay the residential costs for children in DCS custody who need residential treatment.

9. The provision and cost of special education and related services for a child with a disability in DCS custody and living in a detention center shall be provided for in the following manner:

b. If the IEP Team determines that the child should be provided FAPE in the LEA, as the least restrictive environment, the child shall be enrolled in the local LEA where the child is residing. The LEA shall be responsible for providing and paying for special education and related services for the IDEA eligible child not DCS. Absence of a representative from DCS or the local LEA at the IEP Team meeting does not relieve that agency from any responsibilities imposed by this section.

13. When a child who is IDEA eligible is discharged from DCS custody, DCS will notify DOE/Division of Special Education of release information and identify the LEA where the student will be attending school. When a child in DCS custody transitions into the local LEA, DCS will provide the local LEA with the education records of the child consistent with IDEA and FERPA. The schools in the facility or contract agency shall provide the LEA with the education records of children who are IDEA eligible transitioning to the LEA within fourteen (14) calendar days of receipt of the request from the LEA unless there is a critical need to expedite forwarding of the records. However, failure to receive education records does not suspend the responsibility of the LEA to provide FAPE. Nothing in this provision is meant to supersede the requirements of the FERPA, state and federal law and the regulations promulgated thereunder.

14. Medical services for children in DCS custody shall be paid for as follows:

a. TennCare is responsible for the provision of all covered medically necessary services to children in DCS custody who are TennCare enrollees except for services provided at YDCs and detention centers. Medical and behavioral services are provided by the assigned MCO or BHO. However, DCS administers the enhanced mental health and substance abuse benefits for children in DCS physical custody.

b. DCS, when acting as a LEA for a child in DCS custody, will pay for medical services specified in the child's IEP that for the purposes of TennCare are not covered medically necessary services.

c. Children residing in a YDC or detention center are not eligible for TennCare. Therefore, DCS shall contract with appropriate providers, in addition to an on-site nursing staff, to ensure that the necessary medical and mental health services are provided to children in the youth development centers. [The issue is being reviewed by the Attorney General's Office and may change before the Agreement is sent to the Commissioners.]

15. As mandated by IDEA, federal and state law and regulations, DOE will monitor all special education programs and services in all DCS facilities and contract agencies using appropriate monitoring procedures. DOE will assist DCS in providing technical assistance and in-service training to DCS staff, caseworkers, and contract facility administration and teachers in identified areas of need relating to children with disabilities. DCS shall work with contract facility staff and faculty in identifying training needs. DOE, through its monitoring efforts, shall also assess areas needing improvement and coordinate technical assistance through DCS. As a LEA, DCS shall be responsible for submitting a corrective action plan (CAP) to respond to any areas of deficiencies identified by DOE through its monitoring and/or compliance efforts. *See Article 4 Section A - DOE.*

16. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, termination, delay, suspension, or reduction of TennCare

a RMHI and will be returning to the local LEA. The RMHI shall provide, within fourteen (14) calendar days of receipt of request, the education records of children educated at the RMHI who return to the LEA, to a DCS residential facility school, or a contract facility school where the child will be attending school unless there is a critical need to expedite forwarding the records. However, failure to receive such records does not suspend the responsibility of TDMHMR, DCS, or the LEA to provide or cause to be provided special education and related services to a child who is IDEA eligible. The transfer of records will be consistent with IDEA, FERPA, and all other applicable state and federal regulations.

6. When it appears that a child who is IDEA eligible and is receiving care in a RMHI can be provided an appropriate educational program in a less restrictive environment, a representative from the LEA serving the geographical area where the RMHI is located shall be invited by the RMHI to attend an IEP Team meeting to determine the most appropriate educational placement. If the IEP Team determines that the child can be provided FAPE in a less restrictive environment, the child will be enrolled in the LEA where the RMHI is located. The LEA serving the geographic area where the RMHI is located shall be responsible for providing special education and related services under IDEA. Upon enrollment, the financial responsibility for the child's IDEA services shall transfer from TDMHMR to the LEA where the child attends school. All other costs shall be paid in accordance with TCA §33-4 (Mentally Ill and Mentally Retarded Persons - Cost of Services).

7. TDMHMR shall have no responsibility for the costs of special education and related services under IDEA for a child prior to admission to a RMHI, or when a child who is IDEA eligible has been discharged from a RMHI.

8. Nothing in this Agreement is meant to alter or abrogate any contractual agreement between TDMHMR and other parties or agencies regarding the provision of inpatient hospitalization.

9. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension or reduction of mental health services for a child who is receiving mental health services in a RMHI. *TennRule 1200-13-12-.11, Grier revised Consent Decree.*

F. Tennessee Division of Mental Retardation Services

1. The Division of Mental Retardation Services (DMRS) provides services for children with disabilities through the Home and Community Based Services (HCBS) waiver and state funded services available on the basis of state appropriations. Access into the waiver is not guaranteed and is subject to funds available through state appropriations. Services funded by state appropriations are provided to those who are eligible in proportion to the availability of funds. DMRS programs are not an entitlement.

2. DMRS provides support services to children with disabilities and their families who are eligible for services. It does not provide special education or related services as described in IDEA Part B. DMRS does not provide any services directly to individuals with mental retardation in the community. Community based services are funded through DMRS and provided pursuant to contracts between the community organization and the State of Tennessee. DMRS provides

9. As part of the IEP Team process, the LEA should notify DMRS when it believes a child is eligible and may benefit from DMRS services. Consistent with IDEA, the LEA shall be responsible for inviting a DMRS representative to a child's IEP Team meeting when the child reaches age 14, to facilitate planning for the child's transition from school-age services to adult services. DMRS transition services for which a child who is IDEA eligible qualifies must be stated in the child's IEP. The transition plan will be updated annually. *See Article 4 Section B - LEA.*

10. Children in the HCBS waiver are also TennCare eligible. A child in the HCBS waiver shall receive medically necessary covered services through TennCare and chronic mental retardation services through the HCBS waiver. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension or reduction of waiver services. *TennRule 1200-13-12-.11, Grier revised Consent Decree.*

11. In addition to the administrative complaint procedures in Title 33 of the Tennessee Code, DMRS has developed policies and procedures to resolve conflicts in a timely manner. Under Medicaid regulation 42 CFR §431.231, fair hearings and appeals are provided to those persons enrolled in the HCBS waiver.

G. Tennessee Department of Human Services

Division of Rehabilitation Services

1. The Department of Human Services, Division of Rehabilitation Services (DHS/DRS) will provide vocational rehabilitation services for individuals with disabilities who meet DHS/DRS's eligibility criteria. DHS/DRS is not an entitlement program. Services funded by state appropriations, matched with federal funds are provided to those who are eligible in proportion to the availability of funds.

2. An individual with a disability may be self-referred to DHS/DRS, or may be referred by another individual or another agency. A referral may be made by contacting a rehabilitation services office in person, by mail, or by telephone.

3. An individual is eligible for assistance if he is an individual with a disability and requires vocational rehabilitation services to prepare for, secure, retain, or regain employment. *34 CFR §361.42(a).* For DHS/DRS purposes, an individual with a disability means any individual who: 1) has a physical or mental impairment that constitutes or results in a substantial impediment to employment for that individual; and 2) can benefit in terms of an employment outcome from vocational rehabilitation services. *Id.* The determination of eligibility for vocational rehabilitation services shall be based on existing and current information from other programs and providers, the individual and his family. To the extent that such data is unavailable or insufficient for determining eligibility, DHS/DRS shall secure the necessary evaluations to make a determination.

planning. Any services provided by DHS/DRS are available only to the extent that they relate to an employment outcome.

10. DHS/DRS is not an entitlement program and provides services to eligible individuals to the extent funding will allow. Some services are based on an economic need standard that takes into account the number of family members living in the home and available family financial resources. Services which may be provided regardless of financial need include: diagnostic exams, counseling and guidance, maintenance and/or transportation necessary to determine eligibility; job placement, including required union and organizational dues; tuition for post-secondary schools and training; personal/work adjustment; supported employment; tutorial training; orientation and mobility training services; reader, interpreter, translator, attendant or job coaching services; licenses or permits for an occupation or business; and services provided by the Tennessee Rehabilitation Center. Other services available are provided in proportion to the financial resources of the student/family.

11. DHS/DRS is required by Federal law and regulations (29 U.S.C. §721(a)(5)(A) as amended and 34 C.F.R. §361.36) to maintain an order of selection when providing services to persons meeting the basic guidelines for eligibility. Vocational Rehabilitation's order of selection is designed to ensure that persons with the most significant disabilities receive a higher priority for services. Based on prior experience, as well as budgetary expectations, DRS anticipates continuing to be able to serve all eligible individuals who apply for services. The order of selection represents contingency planning which will allow the division to quickly implement services to only priority groups should necessity arise due to funding limitations.

12. When an applicant for vocational rehabilitation services or an individual being provided vocational rehabilitation services is dissatisfied with any action concerning the furnishing or denial of these services, the individual or his representative may file a request for an informal administrative review, mediation, or fair hearing at the nearest vocational rehabilitation office within ten (10) working days of their disagreement or unfavorable treatment by DHS/DRS. *T.C.A. §49-11-612.*

Article Five

IDEA Part C Services

Early Intervention System

The mandate of IDEA Part C is to develop a comprehensive, interagency, multidisciplinary, family-centered and community based services system that is accessible to all infants and toddlers birth to age three with disabilities and their families. The purpose of this Interagency Agreement is to specify the financial responsibility of each Participating Agency and establish procedures for achieving timely resolution of intra-agency and interagency disputes. *34 CFR §303.523.*

A. Collaboration

1. Each Participating Agency shall support the ongoing development and implementation of Tennessee's statewide, comprehensive, coordinated, multidisciplinary, interagency system of

services provided to infants, toddlers, and families that are Part C eligible. *34 CFR §303.501(a).* Each Participating Agency shall incorporate IDEA Part C standards into their monitoring process to ensure that their programs, providers, and contract agencies are in compliance with IDEA. DOE, as lead agency, shall receive a copy of each Participating Agency's monitoring instrument and monitor its format to ensure compliance. DOE shall maintain the option to go on-site with each Participating Agency's monitoring team or to review the agency's monitoring report to fulfill DOE's early intervention system monitoring obligations under IDEA Part C. DOE also has the discretion to follow up with the programs, providers, and contract agencies to ensure the correction of any deficiencies and enforce the requirements of IDEA. *34 CFR §303.501(b).*

B. Referral and Intake

1. Each Participating Agency shall contribute to the development and implementation of a unified system of developmental screening and referral for infants and toddlers birth to three. In order to facilitate referrals and developmental screenings, each Participating Agency shall provide, as appropriate, training and technical assistance to primary referral sources (hospitals-including prenatal and post-natal care facilities, physicians, parents, child care programs, LEAs, public health facilities, and other health care and social service providers) who are required to refer any infant or toddler they suspect is experiencing developmental delay(s) to their local TEIS Point of Entry within two (2) business days after examining or observing the infant or toddler. *34 CFR §303.321.*

2. DOE, in conjunction with TEIS, shall develop and disseminate Part C evaluation procedures and requirements to the Participating Agencies and potential providers and evaluators. DOE/TEIS will train or provide training to evaluators and providers to use the state's eligibility criteria, as outlined in the State's Early Intervention Plan. DOE/TEIS shall also implement uniform procedures for documenting results of the evaluations and assessments for the IFSP Team. Supervision and monitoring activities conducted by DOE/TEIS will ensure timely evaluations and assessments of potentially eligible infants and toddlers.

3. When a Participating Agency finds, suspects, or receives a referral from a primary referral source, the Participating Agency or their agent shall forward that referral immediately to the local TEIS Point of Entry or assign a Service Coordinator to begin a multidisciplinary evaluation process to determine the infant or toddler's eligibility. The multidisciplinary evaluation process must include a minimum of two (2) disciplines. If the agency does not have the capacity to fulfill the responsibility of service coordination and/or arranging for an appropriate eligibility evaluation, that agency will immediately refer the infant or toddler and family to their local district office of TEIS. In every instance, the receiving agency will notify the TEIS district office of all infants and toddlers who are or potentially are Part C eligible.

4. The Service Coordinator will access the evaluation(s) needed for each infant or toddler through the appropriate Participating Agencies as required in IDEA Part C. Each Participating Agency will work collaboratively to ensure the availability of providers to evaluate each infant or toddler suspected to be in need of early intervention services utilizing the state's eligibility criteria promulgated in the Early Intervention State Plan. The providers will evaluate the infant or toddler in all developmental areas, such as adaptive skills, physical (including vision and hearing) development, communication skills, social/emotional development, and cognition.

4. In the IFSP, the payor and the provider of each service will be designated as well as the frequency, intensity, and method of delivering each service. *34 CFR §303.340.* Services will be delivered in a family-centered manner. This includes allowing and encouraging full participation of the family in the planning and implementation of early intervention services and to the greatest extent appropriate, providing services in natural environments and in a manner which incorporates those services into the family's normal lifestyle and routines.

5. Early intervention services, as defined in IDEA Part C and this Agreement, shall be available to infants and toddlers who are IDEA eligible as determined appropriate by the IFSP Team. In addition to meeting the eligibility requirements of IDEA, an infant or toddler must also meet the eligibility requirements of the individual agencies to receive services from that agency.

6. The Service Coordinator shall ensure that transition planning begins no later than the toddler's second birthday. With parental consent, the service coordinator shall refer the toddler to the LEA at age two (2) and arrange for a transition conference no later than ninety (90) days prior to the toddler's third birthday. *34 CFR §303.344(h).* For toddlers who are located and determined to be eligible for early intervention services through TEIS after the age of two (2), a written transition plan shall be included in the initial IFSP. Families will be included in all aspects of transition planning. When a toddler turns age three (3), an IEP must have been developed. In lieu of an IEP, an IFSP, developed in accordance with Part C with appropriate modifications to meet Part B requirements, may be used with the concurrence of the parent. In either case, the IEP or IFSP must be developed by the toddler's third birthday.

7. Each Participating Agency shall support the interdepartmental exchange of information as appropriate and in accordance with IDEA, and all other federal and state laws and regulations regarding confidentiality. DOE has developed an authorization form for the procurement and/or release of a infant or toddler's confidential records to assist in the effective provision of early intervention services. The designated Service Coordinator will ensure that informed consent is obtained from the family before any information is shared. The family may revoke the consent at any time. All information will be released to the family's designated Service Coordinator who shall compile and maintain a complete service file for the child and family. *See Attachment 4 - Early Intervention Release Form.*

D. Tennessee Department of Education

1. DOE has been designated by the Governor as Lead Agency for the State's Early Intervention System mandated by IDEA. *34 CFR §303.500.* Therefore, DOE shall pursue collaborative strategies with all other Participating Agencies that are part of the early intervention system. DOE, as lead agency, shall:

   a. Promulgate standards for early intervention service provision;
   b. Ensure that IDEA Part C funds are not used to replace or supplant any activities required under any other State and Federal program. *34 CFR §303.527(a);*
   c. Provide technical assistance to Participating Agencies, service providers, and contract agencies that provide early intervention services to ensure compliance with the provisions of IDEA Part C. *34 CFR §303.501 (b)(3);*

4. Payment for an early intervention service which is determined necessary by the IFSP team that is appropriately documented on the family's IFSP, and is a service for which a child and family are eligible under MCH or any other DOH programs will be the financial responsibility of DOH.

5. CSS provides reimbursement for medical services for infants or toddlers who meet financial and diagnostic eligibility guidelines. CSS may provide services that have been denied by, or are not covered by, other third party payors but that are considered to be "medically necessary" by the CSS program and the child's provider. Care Coordination services are provided to children who meet the diagnostic eligibility guidelines and may be limited by CSS funding or staff availability. The CSS program does not provide early intervention services other than those related to medical treatment, audiological assessment, physical therapy, occupational therapy, speech-language therapy, therapies, limited DME, and medications. CSS is not an entitlement program.

F. Bureau of TennCare

1. TennCare contracts with MCOs to provide medical care through networks of subcontracted health providers. MCOs are paired with BHOs to create access to a network of providers for enrollees in need of mental health and substance abuse services. TennCare monitors MCOs and BHOs to ensure that they are in compliance with TennCare Rules and are providing accessible in-network providers to TennCare enrollees.

2. TennCare shall perform TennCare eligibility determinations for children who apply for TennCare and conduct EPSDT outreach to help TennCare enrollees receive medically necessary care consistent with *John B.* Consent Decree at pp. 15-18.

3. TennCare is responsible for providing EPSDT services for all children who are TennCare enrollees. EPSDT services include: (a) periodic well-child screenings in accordance with the recommendations of the American Academy of Pediatrics; (b) medically necessary health and behavioral health diagnostic services; and (c) medically necessary health and behavioral health treatment services. EPSDT treatment services include "such other necessary health care, diagnostic services, treatment and other measures [described in §1396d(a)] . . . to correct or to ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State Plan." *42 USC §1396d(r)(5); John B. Consent Decree at p. 5.* EPSDT services are based on the individual child's medical, developmental, and behavioral health needs. No prior authorization by the MCO is needed for a screen conducted by a PCP, and the MCO will provide all medically necessary covered services regardless of whether or not the need for such services was identified by a provider who received prior authorization or by an in-network provider. *John B. Consent Decree at p. 21.* TennCare (including its contractors, the MCOs and BHOs) cannot impose limitations on EPSDT services other than medical necessity. This means that the state cannot set arbitrary limits of duration, scope, or cost of services under EPSDT. *John B. Consent Decree at p. 33.* The MCOs and BHOs have the discretion to require that their network providers deliver TennCare covered services, as long as the networks are sufficient in size and scope to meet the access standards of the MCO/BHO's contract with the state.

9. TennCare shall coordinate the delivery of covered health and behavioral health services with services offered by other state health agencies and shall attempt to make use of other public health, mental health, and educational programs and related programs such as Head Start to ensure an effective child health program.

10. If a child is a TennCare enrollee and early intervention services are provided by TEIS, TEIS may seek reimbursement for these services if it or its providers have a provider contract with the MCO or BHO consistent with the policies and procedures adopted by TennCare, DOE, and this Agreement.

11. The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension, or reduction of medical assistance by the MCO or BHO. Appeals will be handled in accordance with procedures outlined in applicable State rules and as required by the *Grier* revised Consent Decree. *TennRule 1200-13-12-.11.*

G. Tennessee Department of Children's Services

1. No infant or toddler shall be denied early intervention services because of his/her status as a child in DCS custody. A DCS representative shall be present at the IFSP Team meeting for all children who are IDEA eligible in state custody.

2. DCS ensures that department personnel (i.e. case managers) have an opportunity to be trained to make appropriate referrals for infants or toddlers potentially in need of early intervention services. DCS shall also provide foster parents and DCS staff with information regarding Child Find, early intervention services, and the IFSP process. DCS does not provide any early intervention services. However, an agency representative shall be present at an IFSP Team meeting and facilitate the coordination of services in the IFSP and the infant or toddler's DCS Permanency Plan.

H. Tennessee Department of Mental Health and Mental Retardation

Division of Mental Health Services

1. TDMHMR contracts with outpatient agencies to provide Regional Intervention Program (RIP) services. These RIP sites provide services for preschoolers and their families that meet the RIP eligibility requirements. Participation in RIP is not an entitlement and is subject to RIP eligibility requirements not IDEA Part C requirements.

2. RIP provides intensive parent training for families with preschool age children where there is a concern about their behavior.

3. TDMHMR shall ensure that personnel in the department, the Community Mental Health Centers (CMHC), and RIP sites have an opportunity to be trained to make appropriate referrals for infants and toddlers potentially in need of early intervention services. TDMHMR shall also provide staff with information regarding Child Find, early intervention services, and the IFSP process. TDMHMR encourages personnel at the CMHC and RIP sites to attend the IFSP

2. DOE, as lead agency, shall ensure that all due process hearings requested by parents to resolve issues of IDEA eligibility, evaluation, placement, or the provision of appropriate early intervention services will be conducted in accordance with all applicable state and federal statutes and regulations. DOE will maintain a list of state hearing officers and their qualifications. DOE shall appoint hearing officers. All due process hearings under IDEA shall be conducted consistently with state and federal law. *34 CFR §303.420.*

3. Upon request and with the consent of both the parent and the agency providing the early intervention service in dispute, DOE, as lead agency, will assign a mediator to resolve disputes arising under IDEA. DOE will appoint mediators and provide them with training in mediation and special education law. Consent to mediation by the parent of a infant or toddler who is IDEA Part C eligible is voluntary and will not delay or deny a parent's right to a due process hearing nor shall it deny parents any other rights afforded them under IDEA Part C. DOE shall bear the cost of the mediation process. Consistent with IDEA, all discussions that occur during the mediation process must be confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings. The parties to the mediation process are required to sign a confidentiality pledge prior to the commencement of the process. An agreement reached by the parties to the dispute in the mediation process must be set forth in a written mediation agreement. *34 CFR §303.419.*

4. During the pendency of any proceeding involving a complaint under Part C, unless the public agency and the parents otherwise agree, the infant or toddler must continue to receive the appropriate early intervention services currently being provided. If the complaint involves an application for initial services, the infant or toddler must receive those services in the IFSP that are not in dispute. *34 CFR §303.425.*

5. If a written complaint is received that is also the subject of a due process hearing or contains multiple issues, of which one or more are part of that hearing, the State must set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action must be resolved within the 60 calendar day timeline required for resolution of administrative complaints. *34 CFR §303.512(c)(1). See also paragraph one.*

6. If an issue is raised in a complaint that has been decided previously in a due process hearing involving the same parties, the previous hearing decision is binding. A complaint alleging that a public agency or private service provider failed to implement a due process decision must be resolved by the lead agency. *34 CFR §303.512(c)(2).*

7. Procedures for IDEA Part C dispute resolution permit agencies to resolve intra-agency disputes using their own procedures so long as resolution is accomplished in a timely manner. *34 CFR §303.523(2)(i).* DOE, as lead agency, is responsible for ensuring disputes are resolved in a timely manner. Therefore, when an agency is unable to resolve an intra-agency dispute in a timely manner, DOE, as lead agency, shall refer the issue to the informal resolution committee which will resolve the issue in accord with the procedures described in Article 6 of this Agreement. *34 CFR §§303.523.* DOE shall implement procedures to ensure services are provided in a timely manner pending the resolution of disputes among Participating Agencies or service providers by seeing that existing services are not disrupted or if initial services are in dispute that all other services other than the disputed one(s) are provided. *34 CFR §303.525.*

(10) business days after the meeting and distribute it to each Participating Agency. The Participating Agencies shall be responsible for ensuring that the written findings and conclusions are distributed to all offices, divisions, bureaus, units, and programs that may be affected by the findings. The final determination of the Commissioners Task Force shall be binding upon all the agencies. However, the decisions of the Task Force shall not be binding on future complaints but may be considered persuasive authority by the Task Force.

4. While the dispute is pending, the Commissioners Task Force may elect to assign financial responsibility to the agency currently providing the service at issue or if the service has not begun, the Task Force shall allocate resources from the Participating Agencies to provide the service, as appropriate. Once the dispute has been resolved, if the Commissioners Task Force determines that the assignment of financial responsibility was inappropriately made, it shall reassign the responsibility to the appropriate agency. The agency that was originally assigned financial responsibility may seek reimbursement for any expenditures incurred. Each Participating Agency shall establish such policies and procedures as are necessary to assure that any fiscal obligation assessed to it under this Agreement is timely paid or reimbursed.

5. A Participating Agency may refer a general policy question to the Commissioners Task Force for its review and recommendations. The Task Force shall make a policy determination in accord with the applicable state and federal laws and issue written findings that will be distributed to each Participating Agency. The Participating Agencies shall be responsible for ensuring that the written findings are distributed to all offices, divisions, bureaus, units and programs that may be affected by the findings.

Article Seven

Records

1. Pursuant to IDEA, FERPA, and all applicable state and federal laws, the following provisions will apply to the confidentiality and disclosure of education and medical records of IDEA eligible children under this Agreement.

   a. Consistent with state statute, records of students in public educational institutions shall be treated as confidential. Information in such records relating to academic performance, financial status of a student or the student's parent or guardian, medical or psychological treatment or testing shall not be made available to unauthorized personnel of the institution, to the public or to any Participating Agency, except those agencies authorized by the educational institution to conduct specific research, testing, evaluation, provide services or otherwise authorized by the governing board of the institution, LEA, or agency without the consent of the student involved or the parent or guardian of a minor student, except as otherwise provided by law or regulation and except in consequence of due legal process or in cases when the safety of persons or property is involved. The governing board of the institution, DOE, and the Tennessee higher education commission shall have access on a confidential basis to such records as are required to fulfill their lawful functions. Statistical information not identified with a particular student may be released to any person, agency, or the public; and directory information such as information relating only to the individual student's name, age, address, dates of attendance, grade levels completed, class placement and academic degrees awarded may likewise be disclosed. However, if it is disclosed, the

b. An educational agency or institution may disclose personally identifiable information to outside persons performing professional, business, and related services as part of the operations of the institutions if the educational agency or institution has determined that the person has a legitimate educational interest in the information. The privacy protections and confidentiality requirements imposed on the educational agency or institution extend to records and materials maintained by persons acting for the educational agency or institution such as an attorney, accountant or consultant. Improper disclosure by any individual receiving information under this provision will result in the denial of access to educational information by that individual for at least five years. *20 USC §1232g(b)(4)(B).*

c. The educational agency or institution may disclose education records to DCS without parental consent if the child has been placed in DCS custody and will be attending a school administered by DCS. While in the possession of a law enforcement unit, educational records do not lose their status as such.

d. Pursuant to IDEA, an educational agency or institution, when reporting a crime committed by a child with a disability in school to the appropriate authorities, shall transmit copies of the child's special education and disciplinary records. However, the transmittal of records shall only be to the extent allowed under FERPA. Disciplinary records are education records for the purposes of FERPA. *34 CFR §300.529(b).*

e. An educational agency or institution shall disclose education records to a due process hearing officer without parental consent if the disclosure is made in the course of the due process proceeding and not prior to it.

f. An educational agency or institution shall document and record to whom and for what purpose access to records was allowed. This record shall not include parents and authorized employees of the educational agency or institution. *34 CFR §300.565.*

3. Consistent with IDEA, FERPA, and all applicable state and federal regulations, student medical records shall be maintained in the following manner:

a. When maintained by an educational agency or institution for IDEA purposes, EPSDT records shall be considered educational records. An educational agency or institution shall not elect to categorize these records as anything else. If maintained by an educational agency or institution, school health and medical records shall be regarded as confidential education records. School health and medical records, as education records, include school performed screenings, exams, or assistance in the school health office; copies of medical or health related records submitted to schools when they are in the possession of the school; and receipt of services under IDEA.

b. The medical records of patients in state, county, and municipal hospitals and medical facilities, and the medical records of persons receiving medical treatment, in whole or in part, at the expense of the state, county, or municipality shall be treated as confidential and shall not be open for inspection by members of the public. *TCA §10-7-504.* The name, address, and other identifying information of a patient entering and receiving care at a licensed health care facility shall not be divulged unless the disclosure meets one of the enumerated exceptions in TCA §68-11-1503 (Medical Records - Confident[illegible]

Article Twelve

Integration

This Agreement contains all the terms and conditions agreed upon by the Participating Agencies. No other understandings oral or otherwise regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the Participating Agencies.

Article Thirteen

Quality Review

Each Participating Agency shall designate liaisons who will meet annually to review the Agreement to ensure that the Agreement is meeting the needs of the Participating Agencies and recommend any changes or modifications which would benefit any of the Participating Agencies and or children with disabilities and their families. Personnel from the Participating Agencies will initiate a quality review of the services and conditions set forth in this Agreement. Participating Agencies agree to circulate this Interagency Agreement to interested parties including but not limited to LEA superintendents, superintendents of RMHIs *(who else should be included as an interested party?)*, for comments during the period of twelve (12) months after the date in which the Agreement was signed by the commissioners of the Participating Agencies. The Participating Agencies agree to review this Agreement one year from the date of its implementation and thereafter as needed to make such changes as they deem desirable in light of comments received from the interested parties.

Article Fourteen

Assignment

The services to be provided under this Agreement and any claim arising hereunder shall not be assigned or delegated by any Participating Agency, in whole or in part, without the express prior written consent of the other Participating Agencies which consent shall not be unreasonably withheld.

Article Fifteen

Construction

This Agreement is in no way to be construed as limiting or diminishing the responsibilities of the Participating Agencies under federal or state law. In all instances, this Agreement is to be construed to comply with the requirements of federal and state law. This Agreement shall not be construed to create rights in any third parties.

BHO	Behavioral Health Organization
CIT	Children's Information in Tennessee
CMHC	Community Mental Health Center
CSS	Children's Special Services
DCS	Tennessee Department of Children's Services
DHS/DRS	Tennessee Department of Human Services/Division of Rehabilitation Services
DMRS	Tennessee Division of Mental Retardation Services
DOE	Tennessee Department of Education
DOH	Tennessee Department of Health
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FAPE	Free Appropriate Public Education
FERPA	Family Educational Rights and Privacy Act
HCBS waiver	Home and Community Based waiver
ICC	Interagency Coordinating Council
ICF-MR	Intermediate Care Facility - Mental Retardation
IDEA	Individual's with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individual Family Service Plan
IPE	Individual Plan for Employment
ISC	Independent Support Coordinator
ISP	Individual Support Plan
ITP	Individualized Transition Plan
LEA	Local Educational Agency
MCO	Managed Care Organization
PCP	Primary Care Physician
RIP	Regional Intervention Program
RMHI	Regional Mental Health Institute
SEA	State Educational Agency
TCA	Tennessee Code Annotated
TDH	Tennessee Department of Health
TDFA	Tennessee Department of Finance and Administration
TDMHMR	Tennessee Department of Mental Health and Mental Retardation
TEIS	Tennessee Early Intervention System

Attachment Two

TennCare Release Form

Attachment Three

TEIS Release Form

Attachment B

Hearing and Vision Screening Guidelines and Behavioral and Developmental Screening Guidelines

test(s), immunizations, health education, and vision and hearing tests

The state and the committee adopted the American Academy of Pediatrics' Recommendations for Preventive Pediatric Health Care as its basis for developing a schedule of periodic screens. Under EPSDT, there are two types of screens: regularly scheduled, periodic screens and interperiodic screens. Under the consent decree, interperiodic screens are defined as any encounter with a health professional practicing within the scope of his or her practice. Any person who suspects a problem may refer a child for an interperiodic screen. Neither periodic nor interperiodic screens require prior authorization or medical necessity.

The purpose of both periodic and interperiodic EPSDT screens is early identification of possible hearing, vision, developmental, behavioral and dental problems. (Dental screens were outside the purview of this committee's charge. ADA Guidelines have been adopted for dental screens.) Screens as such are not meant to replace thorough diagnostic procedures, but can serve as the basis for referral for additional evaluation.

Technical considerations in screening and in the choice of screening instruments and procedures.

Current screening practices in primary are heavily dependent upon clinical judgement rather than valid instruments. Repeatedly, research shows that this informal technique is grossly ineffective at early detection, rendering more than half of all children with disabilities, and 80% of those with mental health problems, unidentified prior to entrance in school. Opportunities for early intervention are thus missed. The committee's recommendations to use formal measures dovetails well with recommendations from the AAP's Committee on Disabilities.

In reviewing screening instruments, the committee considered both technical characteristics of the instrument and the practicality of instruments for use in primary care. Technical characteristics reviewed were the reliability and validity of the procedures with particular attention to the sensitivity and specificity of the instrument in detecting problems in hearing, vision, development and behavior. When examining the available behavioral and developmental screening instruments, consideration was given to coverage of the major domains of behavioral pathology and development. In all cases, costs of the materials and time costs for administration and interpretation were considered. Other practical considerations were: the appropriateness of the instrument for use in primary care setting, the interpretability of results, extent of training required for staff, reading difficulty of materials given to parents as part of screenings, and acceptability of materials and procedures for the patient population.

Screening of older adolescents (17 & older).

The committee searched for single, comprehensive screens for the older adolescent population. Although specific screening instruments are available to address specific problems such as depression, substance abuse, sexuality issues, eating disorders, etc., no comprehensive instruments [illegible]

some screens for purposes of audit, will expire in the year 2003 (See **Appendix I.**)

Since periodic screenings are an essential part of the EPSDT process, compliance can be enhanced by two major means: evidence of compliance via required and appropriate documentation, and coding of procedures.

Documentation

In order to facilitate the charting of screening services as well as the whole array of EPSDT services, uniform EPSDT chart forms are recommended. The Pediatric Society of Tennessee developed chart forms (see **Appendix II**) covering the entire age range (birth to 21 years) for EPSDT services. The Pediatric Society communicated with the EPSDT Screening Guidelines Committee for comments as the forms were developed and made use of the Committee's comments and suggestions to assure congruence between the forms and the recommendations of the committee. MCO Quality Improvement Directors have endorsed the concept of a uniform chart form.

Coding of services

Another important source of information for determining what EPSDT services were delivered is the coding of the encounter. Encounter codes are used to direct auditors in determining what visits are to be considered as being EPSDT, and may have implications for reimbursement in some circumstances.. Lists of codes capturing EPSDT services are included in **Appendix III.**

Reimbursement

Reimbursement issues were outside the purview of the EPSDT Screening Guidelines Committee. Reimbursement is an issue between providers and MCOs. The committee encourages the MCOs to address reimbursement adjustments to support implementation of appropriate screening. The committee recognizes that additional costs are incurred by providers who implement the recommendations and further recognizes that successful implementation of its recommendations will require improved reimbursement for providers.

Revising and updating the recommendations of the committees.

Screening instruments and guidelines may be modified as new instruments and procedures are developed. The recommendations of the committee represent the most appropriate screening methods as of late 1999.

Members of EPSDT Screening Committee:

Reid B. Blackwelder, M.D.
TN Academy of Family Physicians/
East Tennessee State University
Kingsport, TN

Joel F. Bradley, M.D.
TN Pediatric Society
Clarksville, TN

Madeline Farmer, M.D.
Medical Director, Premier Behavioral Systems of Tennessee
Nashville, TN

Parents' Evaluation of Developmental Status (PEDS)
Ellsworth & Vandermeer Press, Ltd.
4405 Scenic Drive
Nashville, TN
Phone: (615) 386-0061
Fax: (615) 386-0346
http:/www.pedstest.org

Pediatric Symptom Checklist is available through the following publication:

Jellinek, MS, Murphy, JM, Robinson, J, et. al. Pediatric Symptom Checklist: Screening school age children for psychosocial dysfunction. Journal of Pediatrics, 1988; 112:201-209.

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Jellinek, M.S., Murphy, J.M, Robinson, J., Feins, A., Lamb, S. & Fenton, T. (1988). Pediatric symptom checklist: Screening school-age children for psychosocial dysfunction. Journal of Pediatrics, 112, 201-209.

Meisels, S.J. (1989). Can developmental screening tests identify children who are developmentally at risk? Pediatrics, 83, 578-585.

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APPENDIX I

Recommended Vision, Hearing, Developmental & Behavioral Screens

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	Subjective	*Objective*	*Subjective*	*Objective*
4 months	• Parental perception of hearing • Recognizes parent's voice - parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
6 months	• Parental perception of hearing • Turns to sounds - parental report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
9 months	• Parental perception of hearing • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
12 months	• Parental perception of hearing • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision	• Eye exam • Fixes and follows each eye
15 months	• Parental perception of hearing • Response to voice and noise - parent report • Family history (unless previously recorded)	• Ear exam • Observational screening with noisemaker (optional)	• Parental perception of vision • Can see small objects	• Eye exam • Can see small objects

	Recommendations for Hearing Screening		Recommendations for Vision Screening	
	Subjective	*Objective*	*Subjective*	*Objective*
7 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen	• Parental and patient perception of vision	• Eye exam
8 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7 years)	• Parental and patient perception of vision	• Eye exam
9 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7 or 8 years)	• Parental and patient perception of vision	• Eye exam
10 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, or 9 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity
11 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, 9, or 10 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 10 years)
12 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, 9, 10, or 11 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 10 or 11 years)
13 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 7, 8, 9, 10, 11, or 12 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 10, 11, or 12 years)
14 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen	• Parental and patient perception of vision	• Eye exam • Visual acuity
15 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14 years)
16 years	• Parental and patient perception of hearing	• Ear exam • Hearing screen (if not done at 14 or 15 years)	• Parental and patient perception of vision	• Eye exam • Visual acuity (if not done at 14 or 15 years)

VISION SCREENING

- Recommended testing intervals:
  - The committee recommends testing ocular alignment and visual acuity once in the 3-6 year old age range. The procedures should be conducted at the first visit during which the patient is cooperative.
  - The committee recommends testing visual acuity once in each of the following age ranges: 10-13, 14-18.
- Acceptable methods for screening ocular alignment include: photoscreening (preferred), unilateral cover test at 10 feet or 3 M, Random Dot E Sterotest at 40 cm (630 secs of arc).
- Acceptable methods for screening visual acuity include: Snellen Letters, Snellen Numbers, Tumbling F, HOTV, Picture Tests, Allen Figures, LH Tests.
- Positive screening results should lead to referral for diagnostic assessment of vision. A prompt re-screening may be substituted for immediate referral for diagnostic assessment if the clinician believes his initial screening result is likely to be a false positive. Re-screening should be done within 2-4 weeks rather than waiting until the next scheduled well child visit.

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TOOLS THAT ARE RECOMMENDED FOR SECONDARY SCREENING INVOLVING DIRECT TESTING OF CHILDREN

Measure	Age range	Description	Scoring	Accuracy	Time Frame
Brigance Screens. Billerica, MA: Curriculum Associates, Inc. (1985) 153 Rangeway Road, N. Billerica, MA 01862 (1-800-225-0248)	21 to 90 months	Seven separate forms, one for each 12 month age range. Taps speech-language, motor, readiness and general knowledge at younger ages and also reading and math at older ages. Uses direct elicitation and observation.	Cutoff and age equivalent scores	Sensitivity and specificity to giftedness and to developmental and academic problems was 70% to 82%.	10 minutes (direct testing only)

TOOLS THAT ARE NOT RECOMMENDED BUT ARE ACCEPTABLE FOR AUDIT UNTIL 2003

Measure	Age range	Description	Scoring	Accuracy	Time Frame
Denver-II	Birth to 6 years	Combination of directly elicited and interview, tapping language, personal-social, gross and fine motor, but not preacademic or academic skills.	Pass/fail/ Questionable/ untestable	Sensitivity 80% and specificity 40% or sensitivity 40% and specificity 80%, depending on how the questionable score is handled.	15 minutes for younger children, 25 minutes for older children (combination of direct and interview items)
Informal checklists (such as those imbedded in age-specific encounter forms such as Bright Futures)	Birth to 21 years	Usually tap different areas but lack scoring criteria, provide no proof that items tap important skills or predict developmental outcome.	None	Unknown, but research shows that informal methods detect fewer than 30% of children with disabilities	Unknown, but most have about 10 items and so may take about 2 minutes

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2 Week Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
Type or brand _____
With iron ☐ Yes ☐ No
☐ City water ☐ Well water
WIC ☐ Yes ☐ No

Neonatal Metabolic Screen in Chart

☐ Yes ☐ No

Urine Output

Normal Decreased
Strong stream (If male)

Stools

Normal Diarrhea /day
Hard /day

Sleep

Normal (2-4 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

Car seat
Smoke-free environment
Smoke detectors
Crib safety
Baths
Water temperature < 120°
Child proof home

Nutrition

Increase formula
Breast or iron-fortified formula
Infant weight gain
Colic crying

Health

Sleep on back
Know signs of illness
Thermometer use; antipyretics
Emergency procedures
No bottle in bed
Bowel movements
Cord, circumcision care

Social/Behavior

Baby's temperament
Console baby, hold, cuddle, rock, talk, sing
Encourage partner to care for infant
Support from family/friends
Postpartum check-up
Child care

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile
Wt _____ lbs _____ oz _____ %tile
Head Circumference _____ cm _____ %tile
(See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____
☐ Head _____
☐ Eyes _____
☐ Ears _____
☐ Nose _____
☐ Oropharynx _____
☐ Gums/Palate _____
☐ Neck _____
☐ Lungs _____
☐ Heart _____
☐ Abdomen _____
☐ Genitalia _____
☐ Extremities/Hips _____
☐ Spine _____
☐ Neurological _____
☐ Skin/Nodes _____
☐ Other _____

☐ Additional documentation on back
☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Hearing

☐ Responds to sounds
☐ Neonatal ABR or OAE results in chart

Impression

☐ Well infant
☐ Normal growth
☐ Normal development
☐ Other

Plan

☐ Family history, birth history
☐ Newborn metabolic screen
☐ Normal ☐ Pending ☐ Today
☐ RTC for 2 month well check
☐ Referrals
☐ WIC
☐ Transportation
☐ Other referrals

☐ Other

Sign _____

4 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

☐ Breast _____ min _____ per day
☐ Formula _____ oz per day
Type or brand _____
With iron ☐ Yes ☐ No
☐ City water ☐ Well water
WIC ☐ Yes ☐ No

Neonatal Metabolic Screen In Chart

☐ Yes ☐ No

Urine Output

Normal Decreased

Stools

Normal Diarrhea /day
Hard /day

Sleep

Normal (4-6 hours)

New Symptoms/Problems/Complaints

Safety

Anticipatory Guidance Health Education (✓ if discussed)

Car seat
Water temperature <120°
Smoke free environment
Smoke detectors
Child proof home
No baby walker

Nutrition

Breastfeed or iron-fortified formula
Introduce solid food
Avoid honey

Health

Know signs of illness
Sleep on back
Syrup of Ipecac

Social/Behavior

Hold, cuddle, rock
Talk, sing, play music
Partner and sibling involvement
Community involvement
Bedtime routine

Physical Exam ✓= WNL, X=ABN (Describe abnormal findings)

HR _____ in _____ %ntile
Wt _____ lbs _____ oz _____ %ntile
Head Circumference _____ cm _____ %ntile
(See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance
☐ Head
☐ Eyes
☐ Ears
☐ Nose
☐ Oropharynx
☐ Gums/Palate
☐ Neck
☐ Lungs
☐ Heart
☐ Abdomen
☐ Genitalia
☐ Extremities/Hips
☐ Spine
☐ Neurological
☐ Skin/Nodes
☐ Other

☐ Additional documentation on back
☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

☐ WNL (See separate page)
☐ ABN

Vision

☐ Parental observation/concerns
☐ Fixes and follows

Hearing

☐ Parental observations/concerns
☐ Responds to sound (parent report)
☐ Responds to noisemaker (optional)

Impression

☐ Well infant
☐ Normal growth
☐ Normal development
☐ Other

Plan

☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
  ☐ Up to date
  Info read and discussed
  ☐ DTaP/DTP ☐ IPV ☐ HBV ☐ Hib
☐ Acetaminophen _____ mg q 4 hours
☐ Handouts given (4 Mo.)
☐ RTC for 6 month well check
☐ Referrals
  ☐ WIC
  ☐ Transportation
  ☐ Other referrals _____
☐ Other _____

Sign _____

9 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

☐ Breast ___ min ___ per day
☐ Formula ___ ___ oz per day
Type or brand _____
With iron ☐ Yes ☐ No
☐ City water ☐ Well water
WIC ☐ Yes ☐ No

Neonatal Metabolic Screen In Chart

☐ Yes ☐ No

Urine Output

☐ Normal ☐ Decreased

Stools

Normal Diarrhea ___/day
☐ Hard ___ /day

Sleep

Normal (8 hours)

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

Check hazards
Smoke-free environment
No baby walker
☐ Child proof home
Assess lead risk
☐ Car seat
☐ Empty buckets

Nutrition

☐ Breastfeed or iron-fortified formula
☐ Finger foods, mashed food
Avoid choke foods
Supervise eating
☐ Drink from a cup

Health

☐ Brush teeth
☐ Fluoride
☐ Water temperature <120°
☐ No bottle in bed

Social/Behavior

☐ Partner and sibling involvement
Talk, sing
☐ Pat-a-cake, peek-a-boo
☐ Bedtime routine
☐ Exploration opportunities
Limit but enforce rules
☐ Role model healthy habits

Physical Exam ✓= WNL, X=ABN (Describe abnormal findings)

Ht ___ in ___ %ile
Wt ___ lbs ___ oz ___ %ile
Head Circumference ___ cm ___ %ile
(See chart on separate page)

Parent Undclothed ☐ Yes ☐ No

☐ General Appearance

☐ Head

☐ Eyes

☐ Ears

☐ Nose

☐ Oropharynx

☐ Gums/Palate

☐ Neck

☐ Lungs

☐ Heart

☐ Abdomen

☐ Genitalia

☐ Extremities/Hips

☐ Spine

☐ Neurological

☐ Skin/Nodes

☐ Other

☐ Additional documentation on back
☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

☐ WNL
☐ ABN (See separate page)

Vision

☐ Parental observation/concerns
☐ Fixes and follows

Hearing

☐ Parental observations/concerns
☐ Responds to voice and noise (parent report)
☐ Responds to noisemaker (optional)

Impression

☐ Well child
☐ Normal growth
☐ Normal development
☐ Risk assessment for lead exposure
☐ Other

Plan

☐ History updated
☐ Problem list, allergies, medication list updated
☐ Immunizations
  ☐ Up to date
  ☐ Info read and discussed
  ☐ No adverse reactions to prior imm
  ☐ HBV ☐ Other
☐ Hct or Hgb
☐ Lead level ___ mcg/dl
☐ Acetaminophen ___ mg q 4 hours
☐ PPD ___ (result)
☐ Handouts given (9 Mo.)
☐ RTC for 12 month well check
☐ Referrals
  ☐ WIC
  ☐ Transportation
  ☐ Other referrals
☐ Other

Sign _____

15-18 Month Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

- ☐ Whole milk, cup only
- ☐ Solids (serv/day)
  - ___ Meat/Egg
  - ___ Veg/Fruit
  - ___ Bread/Cereal
  - ☐ other _____
- ☐ City water ☐ Well water ☐ Bottled water

WIC ☐ Yes ☐ No

Urine Output

- Normal
- Decreased

Stools

- Normal
- Diarrhea ____/day
- Hard ____/day

Sleep

- Normal (8-12 hours)
- Abnormal

New Symptoms/Problems/Complaints

_____

Anticipatory Guidance Health Education (✓ if discussed)

Safety

- Car seat/ Airbags
- Crib safety/ Crib mattress lowered
- Childproof home
- Window guards
- Smoke-free environment
- Choke foods

Nutrition

- Wean from bottle
- Safe table foods
- Healthy food choices/ No forced foods
- Self-feeding/ Drinking from cup
- Family meals

Health

- Brush teeth
- Proper use of phone/ER

Social/Behavior

- Individual attention
- Exploration/ Physical activity
- Hitting, biting, aggressive behavior
- Enforce rules/ Reassure once negative behavior stops
- Family playtime
- Help toddler express anger/joy
- Short family outings
- Older children
- Toilet training
- Community Programs/ Preschool
- Peek-A-Boo/Pat-A-Cake

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht ____ in ____ %ile

Wt ____ lbs ____ oz ____ %ile

Head Circumference ____ cm ____ %ile

(See chart on separate page)

Patient Undressed ☐ Yes ☐ No

- ☐ General Appearance _____
- ☐ Head _____
- ☐ Eyes _____
- ☐ Ears _____
- ☐ Nose _____
- ☐ Oropharynx _____
- ☐ Gums/Palate _____
- ☐ Neck _____
- ☐ Lungs _____
- ☐ Heart _____
- ☐ Abdomen _____
- ☐ Genitalia _____
- ☐ Extremities/Hips _____
- ☐ Spine _____
- ☐ Neurological _____
- ☐ Skin/Nodes _____
- ☐ Other _____

☐ Additional documentation on back

☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

- ☐ WNL
- ☐ ABN (See separate page)

Vision

- ☐ Parental observation/concerns
- ☐ Can see small objects

Hearing

- ☐ Parental observations/concerns
- ☐ Responds to voice and noise (parent report)
- ☐ Responds to noisemaker (optional)

_____

Impression

- ☐ Well child
- ☐ Normal growth
- ☐ Normal development
- ☐ Low risk for lead exposure
- ☐ Low risk for tuberculosis
- Other

_____

Plan

- ☐ History updated
- ☐ Problem list, allergies, medication list updated
- ☐ Immunizations
  - ☐ Up to date
  - ☐ Info read and discussed
  - ☐ No adverse reactions to prior imm.
  - ☐ DTaP/DTP ☐ Hib ☐ MMR
- ☐ Hct or Hgb ____
- ☐ Referrals
  - ☐ WIC
  - ☐ Transportation
  - ☐ Other referrals _____
- ☐ Other _____

Sign _____

3 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

☐ Food (serv/day)
___ Meat/Egg
___ Veg/Fruit
___ Bread/Cereal
☐ other _____
☐ City water ☐ Well water ☐ Bottled water
WIC ☐ Yes ☐ No

Urine Output

☐ Normal ☐ Decreased

Stools

☐ Normal ☐ Diarrhea ___/day
Hard ___/day

Sleep

☐ Normal (8-12 hours)
☐ Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

☐ Playground/Stranger
☐ Seatbelts/Booster seats
☐ Fires/Burns

Nutrition

☐ See Dentist/ Brush teeth
☐ Family meals
☐ Variety/Low fat/Limit sweets

Social/Behavior

☐ Exploration/ Physical activity
☐ Socialization
☐ Praise/ Talking/ Interactive reading
☐ Sibling relationships
☐ Limit TV

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht ___ in ___ %tile
Wt ___ lbs ___ oz ___ %tile
(See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance
☐ Head
☐ Eyes
☐ Ears
☐ Nose
☐ Oropharynx
☐ Gums/Palate
☐ Neck
☐ Lungs
☐ Heart
☐ Abdomen
☐ Genitalia
☐ Extremities/Hips
☐ Spine
☐ Neurological
☐ Skin/Nodes
☐ Other

☐ Additional documentation on back
☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

☐ WNL (See separate page)
☐ ABN

Vision

☐ Parental observation/concerns
☐ Can see small objects
☐ Ocular alignment
☐ Visual acuity (optional)
___R ___L ___Both

Hearing

☐ Parental observations/concerns
☐ Screening audiometry (optional)
☐ Screening with noisemaker (optional)

Impression

☐ Well child
☐ Normal growth
☐ Normal development
☐ Low risk for lead exposure
☐ Low risk for tuberculosis
☐ Low risk for hyperlipidemia

Plan

☐ History updated
☐ Problem list, alergies, medication list updated
☐ Immunizations
  ☐ Up to date
  ☐ Info read and discussed
  ☐ No adverse reactions to prior imm
☐ Hct or Hgb ___ ___
☐ Acetaminophen ___ ___mg q 4 hours
☐ Handouts given (3 year)
☐ Urinalysis
☐ RTC for 4 year well check
☐ Referrals
  ☐ WIC
  ☐ Transportation
  ☐ Dental
  ☐ Other referrals ___
☐ Other ___

Sign _____

5 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition

☐ Food (serv/day)
- ___ Meat/Egg
- ___ Veg/Fruit
- ___ Bread/Cereal
- ___ Milk/Dairy

☐ other _____

☐ City water ☐ Well water ☐ Bottled water

WIC ☐ Yes ☐ No

Urine Output

Normal Decreased

Stools

Normal Diarrhea ___/day

Hard ___/day

Sleep

Abnormal

New Symptoms/Problems/Complaints

Anticipatory Guidance Health Education (✓ if discussed)

Safety

Pedestrian/Playground/Stranger

Car seat/Seat belt/Bike Helmet

Nutrition

Healthy meals and snacks

Dental sealants

Family meals

Health

Adequate sleep/Physical activity

Tooth care/Dental exams

Curiosity about sex

Social/Behavior

Family Rules/Respect/Right from wrong

Praise/Encourage

Handle anger/Conflict resolution

Prepare child for school

Tour school/Meet teachers

Affection

Physical Exam ✓= WNL, X=ABN (Describe abnormal findings)

Ht _____ in _____ %tile

Wt _____ lbs _____ oz _____ %tile

(See chart on separate page)

Patient Unclothed ☐ Yes ☐ No

☐ General Appearance _____

☐ Head _____

☐ Eyes _____

☐ Ears _____

☐ Nose _____

☐ Oropharynx _____

☐ Gums/Palate _____

☐ Neck _____

☐ Lungs _____

☐ Heart _____

☐ Abdomen _____

☐ Genitalia _____

☐ Extremities/Hips _____

☐ Spine _____

☐ Neurological _____

☐ Skin/Nodes _____

☐ Other _____

☐ Additional documentation on back

☐ Additional documentation on separate page

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen

☐ WNL

☐ ABN (See separate page)

Vision

☐ Parental observation/concerns

☐ Can see small objects

☐ Ocular alignment

☐ Visual acuity (optional)

___ R ___ L ___ Both

Hearing

☐ Parental observations/concerns

☐ Screening audiometry, if not done at 3 or 4 years

Impression

☐ Well child

☐ Normal growth

☐ Normal development

☐ Low risk for lead exposure

☐ Low risk for tuberculosis

☐ Low risk for hyperlipidemia

☐ Other _____

Plan

☐ History updated

☐ Problem list, alergies, medication list updated

☐ Immunizations
- ☐ Up to date
- ☐ Info read and discussed
- ☐ No adverse reactions to prior imm.
- ☐ DTaP/DTP ☐ IPV ☐ HBV ☐ MMR

☐ Other _____

☐ Hct or Hgb _____

☐ UA

☐ PPD

☐ Lead level _____ mcg/dl

☐ Urinalysis

☐ RTC for 6 year well check

☐ Referrals
- ☐ Transportation
- ☐ Dental
- ☐ Other referrals _____

☐ Other _____

Sign _____

V.f.11.

10-14 Year Preventive Visit Form

DATE _____ NAME _____ DOB _____

Allergies: _____

Meds: _____

History

Nutrition
- Food (serv/day)
  - ___ Meat/Egg
  - ___ Veg/Fruit
  - ___ Bread/Cereal
  - ___ Milk/Dairy
- other _____
- City water Well water Bottled water

Urine Output
Normal Decreased

Stools
Normal Diarrhea ___/day
Hard ___/day

Sleep
Normal (8-12 hours)
Abnormal

Menstrual
Premenarchal
Normal
Abnormal

New Symptoms/Problems/Complaints

Physical Exam ✓=WNL, X=ABN (Describe abnormal findings)

Ht ___ in %tile
Wt ___ lbs ___ oz %tile
(See chart on separate page)

Patient Undressed Yes No

- General Appearance
- Head
- Eyes
- Ears
- Nose
- Oropharynx
- Gums/Palate
- Neck
- Lungs
- Heart
- Abdomen
- Genitalia
- Extremities/Hips
- Spine
- Neurological
- Skin/Nodes
- Other

Screening ✓=WNL, X=ABN

Developmental/Behavioral Screen
- Sexual development and behaviors (abstinence, STD prevention, BC)
- Tobacco Alcohol/Substance/Anabolic steroid use/avoidance
- Body image and dieting patterns
- Emotional, physical and sexual abuse
- Emotional (Depression, Anxiety)
- School/Work problems
- Peer relationships
- Family relationships

Vision
- Patient concerns
- Visual acuity
  ___ R ___ L ___ Both

Hearing
- Patient concerns
- Screening audiometry, if not done previously

Impression
- Well adolescent
- Normal growth
- Tanner Stage
- Normal development
- Low risk for tuberculosis
- Low risk for hyperlipidemia
- Other

Anticipatory Guidance Health Education (✓ if discussed)

Safety
- Seatbelts/Helmets/Sunscreen
- Weapons

Nutrition
- Variety/Limit sweets
- Adequate Iron in females
- See Dentist
- Weight management
- Weight training/Changes
- Adequate sleep/Exercise

Health
- See Dentist
- Stress/Nervousness/Sadness
- Alcohol/ Drugs/ Tobacco
- How to say no/Abstinence
- Sexual feelings normal
- Body changes

Social/Behavior
- Family time
- Peer pressure/Refusal
- School activities
- Religious/Cultural/Volunteer activities

Plan
- History updated
- Problem list, allergies, medication list updated
- Immunizations
  - Up to date HBV Td
  - MMR Varicella
- Other
- Hct or Hgb
- UA
- PPD
- School Forms completed
- Urinalysis
- RTC for well check
- Referrals
  - Transportation
  - Dental
  - Other referrals
- Other

Additional documentation on back
Additional documentation on separate page

Sign _____

APPENDIX III

EPSDT Codes

Attachment C

EPSDT Articles

including Family Medicine, to develop the guidelines. The consent decree also requires the adoption of the screening schedule found in the American Academy of Pediatrics' Recommendations for Preventive Pediatric Health Care. (Dental screens are also part of this process and American Dental Association Guidelines were adopted to fulfill this requirement)

The task for the committee was to recommend screening guidelines that might be readily adaptable to primary care settings. Technical characteristics reviewed were the reliability and validity of the procedures, with particular attention to the sensitivity and specificity of the instrument in detecting problems. Cost and the practicality of administering the screens were also important considerations. Behavioral and developmental screens posed a particular challenge due to the need to tailor screens to meet the multiplicity of needs of children from infancy through adolescents.

An extensive pilot study was conducted during the summer of 1999 in two large practices to evaluate the recommended screenings. To further facilitate documentation and fulfillment of EPSDT requirements, the committee worked closely with a committee of The Tennessee Pediatric Society who developed chart forms that incorporate components of the EPSDT visit.

The outcome of the process is a series of recommended guidelines that the committee considers being the most appropriate practices now available. Hearing and vision guidelines incorporate recommendations for objective and subjective screens. There are

TNCare Changes Child Health Supervision Visit Requirements

In March of 1998 the State of Tennessee entered into a consent decree mandating that it fulfill Federal Early Periodic Screening Diagnosis and Treament (EPSDT). Major requirements of the consent decree include the adoption of the screening schedule found in the American Academy of Pediatries' Recommendations for Preventive Pediatric Health Care and from the American Dental Association. To facilitate and define these guidelines, the Bureau of TennCare convened an EPSDT Screening Guidelines Committee with broad representation from various health care specialties, including Pediatrics, Family Medicine and Nursing.

The Committee focused on vision, hearing, developmental and behavioral screening methods suitable for busy primary care settings. Technical characteristics of various measures and methods reviewed were the reliability and validity of the procedures, with particular attention to the sensitivity and specificity of the instrument in detecting problems. Cost and the practicality of administering the screens were also important considerations. Behavioral and developmental screens posed a particular challenge due to the need to tailor screens to meet the multiplicity of needs of children from infancy through adolescents.

An extensive pilot study was conducted during the summer of 1999 in two large practices to evaluate the recommended screenings. To further facilitate documentation and fulfillment of EPSDT requirements, the committee worked closely with a committee of the Tennessee Pediatric Society who developed age-specific encounter forms that incorporate components of the EPSDT visit.

Attachment D

Schedule of EPSDT Guidelines Training Workshops and Tentative Agenda

Tentative Agenda
(Jackson and Memphis locations only)

9:00 – 9:30	Registration
9:30 – 11:00	Introduction/EPSDT Overview A. EPSDT Requirements B. EPSDT Consent Decree C. EPSDT Screening Guidelines Committee
11:00 – 12:00	Hearing/Vision Screening Guidelines
12:00 – 1:00	Lunch
1:00 – 2:00	Behavioral/Developmental Guidelines
2:00 – 2:30	Enhancing the EPSDT Program in Your Practice
2:30 – 3:00	Wrap-up/Questions & Answers

Attachment E

HCFA Report 416
and
Progress Toward EPSDT Targets

DATE 05/02/00

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT
TENNCARE MANAGEMENT INFORMATION SYSTEM
REPORTING PERIOD OCT 01, 1998 - SEP 30, 1999

TNMEP500
DHHS/HCFA

FORM APPROVED
OMB NO- 0938-035[illegible]

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

STATE TN FY 1999

			AGE GROUPS						
	CAT	TOTAL	<1	1-2 *	3-5	6-9	10-14	15-18	19-2[illegible]
9. TOTAL ELIGIBLES RECEIVING AT LEAST ONE INITIAL OR PERIODIC SCREEN	CN	86045	15073	20122	18932	9076	9728	7996	511[illegible]
	MN	72401	8781	14166	16164	7576	8663	11097	595[illegible]
	TOTAL	158446	23854	34288	35096	16652	18391	19093	1107[illegible]
10. PARTICIPANT RATIO	CN	.27	.51	.28	.33	.25	.14	.23	.33
	MN	.25	.61	.33	.35	.25	.13	.18	.22
	TOTAL	.26	.54	.30	.34	.25	.14	.20	.26
11. TOTAL ELIGIBLES REFD FOR CORRECTIVE TREATMENT	CN	121565	15774	22076	22874	19964	21727	12756	6394
	MN	115742	9122	15852	19980	19329	22211	20417	8831
	TOTAL	237307	24896	37928	42854	39293	43938	33173	15225
2A. TOTAL ELIGIBLES RECEIVING ANY DENTAL SERVICES	CN	97061	1928	5848	18206	27583	25030	12460	6006
	MN	104337	1151	5098	16819	26231	25460	20567	9011
	TOTAL	201398	3079	10946	35025	53814	50490	33027	15017
2B. TOTAL ELIGIBLES RECEIVING PREVENTIVE DENTAL SERVICES	CN	74558	433	3390	15070	24498	21531	7577	2059
	MN	78936	176	2582	13719	23065	21694	13454	4246
	TOTAL	153494	609	5972	28789	47563	43225	21031	6305
2C. TOTAL ELIGIBLES RECEIVING DENTAL TREATMENT SERVICES	CN	37499	318	1266	6480	11155	10852	5505	1923
	MN	49436	160	1242	6900	12585	12900	11170	4479
	TOTAL	86935	478	2508	13380	23740	23752	16675	6402
13. TOTAL ELIGIBLES ENROLLED IN MANAGED CARE	CN	379260	29291	71666	62734	78812	76797	41496	18464
	MN	343589	14508	42550	50537	66168	69843	68048	31935
	TOTAL	722849	43799	114216	113271	144980	146640	109544	50399
14. TOTAL NUMBER OF SCREENING BLOOD LEAD TESTS	CN	10615	2334	2847	4396	690	269	65	14
	MN	5864	1301	1846	2192	328	123	51	23
	TOTAL	16479	3635	4693	6588	1018	392	116	37

FORM HCFA-416 (06-02)

* INCLUDES 12-MONTH VISIT
NOTE: "CN" = CATEGORICALLY NEEDY, "MN" = MEDICALLY NEEDY

4. Any encounter with a health professional practicing within the scope of his/her practice is an interperiodic screen. Any person such as an educator, parent, or health professional who suspects a health problem may refer a child for an interperiodic screen. An interperiodic screen does not have to include any screening elements required for a periodic screen. No prior MCO authorization is required for an interperiodic screen, and the MCO shall provide all medically necessary covered services identified by the interperiodic screen. *John B. Consent Decree at p. 23.*

5. The child's MCO will be responsible for identifying whether or not the child's EPSDT screenings are up-to-date and shall be responsible for providing screenings as needed. These screens shall be provided by the child's PCP under contract with the MCO. When it is suspected that a TennCare enrolled child may have a particular medical or behavioral health problem and the child is up-to-date on his EPSDT screenings, the child should be referred to the child's PCP for an EPSDT interperiodic screen. The PCP will make recommendations to the MCO/BHO if he/she believes there is a need for additional diagnosis and/or treatment that is medically necessary. *John B. Consent Decree at p. 38.*

6. TennCare will provide all covered medically necessary services, including durable medical equipment, for all children who are TennCare enrollees, regardless of whether or not these children are IDEA eligible. TennCare shall provide transportation to and from appointments for services covered by TennCare when the enrollee does not have access to transportation services. *John B. Consent Decree at pp. 41-2.* TennCare may not disqualify an eligible service for TennCare reimbursement because that service is provided in accord with an IFSP. *34 CFR §303.527(c).* MCOs and BHOs have the discretion to require that covered services be delivered by providers in their networks, within the access standards required in their contracts with the state.

7. Emergency medical services are available twenty-four (24) hours per day, seven (7) days per week for TennCare enrollees. Coverage of emergency medical services is not subject to prior authorization by the MCO. *Tenn.Rule 1200-13-12-.04(4)*

8. Each TennCare MCO and BHO is responsible for the management of medical care and continuity of care for all its TennCare enrollees including children who are IDEA eligible. Specific responsibilities include performance of reasonable preventive health case management services, appropriate referral and scheduling assistance for enrollees needing specialty health care services, monitoring of enrollees with ongoing medical conditions, coordinated hospital and/or institutional discharge planning that includes post-discharge care as appropriate, maintenance of an internal tracking system which identifies the current preventive service screening status and pending due dates for each enrollee, and authorization of out-of -plan or out-of-state services which are medically necessary due to an emergency. *Contractor's Risk Agreement between TennCare and MCO September, 1995.* In addition, to coordinate EPSDT screens and services, each TennCare MCO/BHO shall provide case management services by assisting children for whom case management is medically necessary. *John B. Consent Decree at p. 38.* The case management provided shall center on the process of collecting information on the health needs of the child, making and following up on referrals as necessary, and activating the examination/diagnosis/treatment loop. *Id. at pp. 38-9.* The case management services must meet the needs of the child and cannot be used exclusively as a tool for prior authorization. *Id. at p. 39.*

d. Monitor all early intervention programs and services provided to infants and toddlers and their families that are Part C eligible whether or not they are supported by IDEA Part C funds. *34 CFR §303.501 (b)(1);* and

e. Ensure that disputes regarding payment or provision of services are resolved in a timely manner.

2. In addition to its responsibilities as lead agency, DOE shall provide and pay for early intervention services documented on the family's IFSP for which there is no other responsible payor. DOE's responsibility will be limited to the services specified under IDEA. Part C funds will not be utilized for payment for any service which is considered experimental in nature. *34 CFR §303.527.*

3. When a family consents to accessing its private insurance for early intervention services, DOE will utilize Part C funds to cover deductibles and copayments to ensure that the services are provided at no cost to the family unless DOE establishes a system of sliding fees. DOE funds cannot be used to supplement payment for services covered by any other program supported by federal, state, or local funds. *34 CFR §303.527 (a).*

4. When a family declines the use of private insurance for early intervention services indicated on the IFSP for which there is no other responsible payor, DOE will secure the service(s), via the local TEIS office, from a provider who has agreed to provide the service in a manner and cost rate established by DOE. DOE shall assume the costs of these services only if it is in accordance with the payor of last resort provisions of IDEA Part C and appropriately documented in a current IFSP. *34 CFR §303.527(a).*

E. Tennessee Department of Health

1. Department of Health (DOH) programs that may have infants or toddlers in need of early intervention services include the Maternal and Child Health (MCH) Title V programs of Children's Special Services (CSS), Healthy Start, HUG, WIC, and child health EPSDT services. Other DOH programs include Traumatic Brain Injury, Hemophilia, Ryan White, and Renal. DOH services are not an entitlement program.

2. DOH ensures that department personnel in child health programs shall be trained to make appropriate referrals for infants and toddlers potentially in need of early intervention related services. DOH shall also provide enrolled families and staff with information regarding Child Find, early intervention services and the IFSP process.

3. DOH programs, that provide services to infants and toddlers birth to 3 years of age identified with a developmental delay and IDEA Part C eligible, will appropriately document the type and amount of service and/or reimbursement provided for the infant, toddler or family as determined by the IFSP. The DOH program representative or authorized representative shall participate on the IFSP team to assist in the process to determine the amount and type of service to be provided or reimbursed by the DOH program and to assist in the process to determine the lead service coordinator. All services provided or reimbursed must meet the CSS program rules and regulations, scope of service and policy.

The multidisciplinary evaluation process must be completed and an IFSP developed within forty-five (45) calendar days from the date of receipt of the referral by the primary referral source if the infant or toddler is found to be IDEA eligible. *34 CFR §303.321(e).* Early intervention services and evaluations must be provided within a reasonable time period. Therefore, in order to ensure that evaluations and early intervention services are provided in a timely and efficient manner, DOE/TEIS may contract with appropriate providers or provide the needed evaluations and/or services itself pending reimbursement from the agency that has ultimate responsible for the payment or in accordance with the payor of last resort requirements. *34 CFR §303.527(b).* In order to receive reimbursement from TennCare, the service provider must be a TennCare provider.

C. Provision of Services

1. Early intervention services must be provided in collaboration with parents to meet the developmental needs of the infant or toddler. Qualified personnel, under public supervision, and in accordance with a current IFSP shall provide these services. Early intervention services shall be provided at no cost to parents unless a system of sliding fees has been implemented by the Participating Agency or the Lead Agency (DOE). *34 CFR §303.521.* The use of private insurance must be voluntary and consented to in writing by the parents. This written consent shall be obtained by a representative of the local TEIS Point of Entry. If a parent consents to access private insurance for early intervention services, Part C funds may be used to pay the family's copayment assessed by the insurance company. Each Participating Agency shall promote the provision of early intervention services to infants and toddlers to the greatest extent appropriate, in natural environments, including the home and community settings in which infants and toddlers without disabilities participate. *34 CFR §303.12 (a),(b).*

2. Once an infant or toddler has been determined to be eligible for early intervention services, the IFSP Team will meet to develop a comprehensive plan of early intervention services. The IFSP Team will include the service coordinator, the infant or toddler's parents and other family members, as requested by the parent, an advocate or person outside the family, if the parent requests his/her participation, person(s) directly involved in conducting the evaluations and assessments, and persons from the Participating Agencies who will be providing services to the infant, toddler or family, as appropriate. *34 CFR §303.343.* The IFSP team will, with concurrence of the family, designate a Service Coordinator. The Service Coordinator may be the service coordinator who was initially assigned to the infant or toddler during the evaluation process or it may be someone different. The Service Coordinator shall be from the agency most relevant to the needs of the infant or toddler and family to ensure the implementation of the IFSP in compliance with IDEA Part C. *34 CFR §303.344(g).* The Service Coordinator shall be responsible for coordinating any additional evaluations and assessments, as necessary; facilitating the IFSP meeting and development of the IFSP; coordinating with medical and health providers; and coordinating and monitoring the delivery of the services indicated in the IFSP.

3. DOE, with the assistance of the other Participating Agencies, shall provide training and technical assistance to Service Coordinators to assist them in performing the requirements of service coordination particularly facilitating the interaction between families and service providers. DOE will establish a technical assistance system to support service coordinators and service providers. DOE is also responsible for monitoring service coordination.

early intervention services for all infants and toddlers with disabilities and their families. Each Participating Agency shall support and assist the coordination of payments for these early intervention services from all public and private sources to enhance the State's capacity to provide quality early intervention services and to expand and improve existing services. *34 CFR §303.01.*

2. The Commissioner of each Participating Agency that is involved in the provision of or payment for early intervention services shall appoint a representative with sufficient authority to engage in policy planning and implementation on behalf of their Agency to serve on the ICC. *34 CFR §303.600 et seq.*

3. Each Participating Agency agrees to support the ongoing development of policies and procedures which will ensure that all infants and toddlers with disabilities and their families have timely and efficient access to appropriate service coordination, evaluations, referrals, services, transition planning, and implementation. Each Participating Agency shall promote and support the implementation of such policies and procedures within their agency and contract providers to ensure compliance with federal statutes and regulations regarding infants and toddlers with disabilities.

4. Each Participating Agency shall conduct individual or coordinated efforts to provide information to the public regarding Tennessee's system of early intervention services to include information on accessing the service system. *34 CFR §303.320.* Each agency, on the state and local level, shall submit and annually update information to be included in Tennessee's Central Directory of services and will, as appropriate, assist in the distribution of this Directory. *34 CFR §303.301.*

5. Each Participating Agency shall provide training and technical assistance to its service providers and, to the greatest degree appropriate, the staff of other Participating Agencies, regarding their roles and responsibilities in the provision of early intervention services in accordance with IDEA Part C.

6. Each Participating Agency shall appoint a representative, with the capacity to speak on behalf of the Participating Agency, to participate in Local Interagency Coordination Councils to facilitate collaboration in the planning, coordination, and provision of early intervention services at the local level. Each Participating Agency shall also encourage its local providers to participate in Local Interagency Coordination Councils.

7. Each Participating Agency shall ensure that its service coordinators, as appropriate, on the local level provide information regarding parental rights and procedural safeguards under IDEA to families of infants and toddlers who are IDEA Part C eligible and are being served by their agency.

8. Each Participating Agency shall ensure that its services providers, as appropriate, submit data to the lead agency (DOE) on an annual basis to fulfill the requirements of IDEA and its accompanying Federal Regulations for submission of the December 1 Child Count to the U.S. Department of Education/Office of Special Education Programs.

9. Each Participating Agency, pursuant to individual agreements with the lead agency, shall assist the lead agency (DOE) in facilitating the monitoring of early intervention programs and services to ensure quality and compliance with IDEA and federal and state regulations for

4. Eligibility determinations will be made by DHS/DRS. Determinations made by officials of other agencies, particularly education officials, regarding whether an individual has a qualifying disability, shall be used, to the extent appropriate and consistent with the requirements of the Rehabilitation Act of 1973 as amended (29 USC §720 *et seq.*), in assisting DHS/DRS in making such determinations. *34 CFR §361.42(c)(1)(2).*

5. To the extent possible, DHS/DRS will make available a vocational rehabilitation counselor to participate in the IEP Team meeting when requested by the LEA. The rehabilitation counselor will assist in the formulation of an IEP/ITP and secure a copy of the IEP/ITP for the student's DHS/DRS case record if the student is eligible for vocational rehabilitation services. The vocational rehabilitation counselor will establish and maintain a working relationship with special education supervisors, vocational education supervisors, directors, secondary school guidance counselors and staff of DMRS.

6. Twelve to eighteen months prior to the student's exit from school, the LEA will provide DHS/DRS the most current copies of medical, psychological, vocational, and social evaluations and all other available information needed for establishing eligibility and identifying vocational rehabilitation needs of each student referred for services. If the information is not appropriate, DHS/DRS may need to secure current information to provide a basis for an eligibility determination.

7. When DHS/DRS determines a student with a disability will be eligible for vocational rehabilitation services, the student, and the student's parent/guardian if appropriate, will develop an Individualized Plan for Employment (IPE), with the assistance of a Vocational Rehabilitation Counselor or other technical assistance as required. The IPE will include the specific employment outcome chosen by the student, consistent with the student's unique strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice, in an integrated setting to the maximum extent appropriate. It will include a description of vocational rehabilitation services to be provided by DHS/DRS, timelines for initiation of services and achievement of the employment outcome. Also included are the vendors and method of procuring services, criteria to evaluate progress, and the terms and conditions of the IPE. If applicable, information about any projected need for rehabilitation technology, personal care assistance, supported employment, or post-employment services will be included.

8. DHS/DRS begins to help coordinate transition services to high school students with disabilities, who meet DHS/DRS eligibility criteria, 12-18 months prior to their exit from school to assist them in gaining employment. Transition services are provided jointly by DHS/DRS through Vocational Rehabilitation Counselors. A Vocational Rehabilitation Counselor will assist in coordinating services including vocational evaluation, training, placement, and other services either directly, or through referral to appropriate agencies. The types of services provided are based on the needs of the individual. DHS/DRS will coordinate and/or provide vocational rehabilitation post-secondary training and job placement, and participate in public and professional awareness activities regarding availability of services.

9. DHS/DRS will provide vocational rehabilitation services to an eligible individual. These services include any services listed in an IPE necessary to assist an individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual. DHS/DRS will coordinate assessment activities and program

oversight to these programs. DMRS encourages all Participating Agencies to communicate with DMRS when a child may qualify for DMRS services. Early referrals facilitate timely delivery of services when available.

3. DMRS administers a Family Support Program to help meet the needs of families who have a member with severe disabilities. The program provides a variety of services that emphasize community living and are responsive to family needs. The program is not intended to pay for services that are provided to individual families through other programs such as the HCBS waiver, TennCare, Medicare or private insurance. Family Support Program services are only available to the extent funding will allow.

4. If a child who is IDEA eligible is residing in one of the DMRS Developmental Centers, the local LEA will ensure that the child receives FAPE in the least restrictive environment. The local LEA will convene an IEP Team meeting to determine eligibility, and develop and implement an appropriate IEP in accordance with IDEA and all applicable state and federal regulations. The local LEA is responsible for the cost and provision of special education and related services. Residential costs for children residing in developmental centers are paid for by Medicaid through ICF/MR (Intermediate Care Facility for the Mentally Retarded) funds.

5. The HCBS waiver was created so that individuals with mental retardation could live in community settings or the family home rather than developmental centers. To qualify for the HCBS waiver, the individual must meet the financial eligibility requirements of TennCare and Medicaid. DMRS shall administer a preadmission evaluation process to determine if a child has the requisite disability to qualify for the waiver. There are no age requirements connected with the HCBS waiver. However, to be eligible for day habilitation or supported employment services, a person shall be twenty-two years old or have a high school diploma and no longer be eligible to receive services under IDEA. The HCBS waiver pays for non-educational services provided in the community. Special education and related services are provided to all children who are IDEA eligible in the HCBS waiver by the LEA where the child is attending school.

6. Everyone in the HCBS waiver shall have an independent support coordinator (ISC). If a child is not eligible for the waiver but is receiving DMRS services, a case manager from a DMRS regional office or from the service provider shall be assigned to coordinate the services the child receives. The ISC or case manager shall be responsible for developing the child's Individual Support Plan (ISP) which identifies the needs and services for each child as well as goals and timelines for the delivery of services. The ISP will describe all services to be furnished, their frequency, and the type of provider who will furnish and pay for each.

7. The role of the ISC is to be an advocate for the individual and the family. The ISC shall find and gain access to necessary supports and services, and coordinate and monitor their delivery. The ISC shall determine the extent to which the supports and services meet the needs and expectations of the individual, the family, and others who participated in the development of the support plan.

8. The ISC or DMRS case manager shall attend the IEP Team meeting of a child who is IDEA eligible. At the IEP team meeting, the ISC will work with the other team members to assure that the ISP and the IEP complement each other to provide the child with the most comprehensive and effective service plan. To the extent possible, DMRS, in conjunction with DOE, will provide technical assistance to parents, case managers, and ISCs regarding the IEP process.

services for a child in DCS custody. *TennRule 1200-13-12-.11, see also Grier revised Consent Decree.* Children in DCS custody receiving enhanced behavioral health services provided by DCS may appeal to the Solutions Unit. In addition to the medical and enhanced behavioral health procedures, DCS has developed policies and procedures to resolve complaints and grievances in a timely manner.

E. Tennessee Department of Mental Health and Mental Retardation

Division of Mental Health Services

1. No eligible child shall be denied special education and related services in the least restrictive environment due to his/her status as a child residing in a Regional Mental Health Institute (RMHI). Placement in a RMHI may not be solely an educational placement but must meet the requirements of one of the applicable state statutes governing psychiatric hospitalization. A child must be admitted by a physician pursuant to state statutes (TCA §§33-6-101, 33-6-103-104, 33-3-401, 33-3-412, and 37-1-128). Except in circumstances of an emergency, as defined in TCA §33-6-103 and §33-3-412, admission to a RMHI is subject to the availability of suitable accommodations. TDMHMR will provide care for all children who are residing in a RMHI, as provided in state and federal law. All educational placements must remain with the child's IEP Team.

2. TDMHMR will assume the costs of special education and related services for all children who are IDEA eligible in a RMHI through state appropriations if the child meets the statutory requirements for hospitalization pursuant to state statutes (TCA §§33-6-101, 33-6-103-104, 33-3-401, 33-3-412, and 37-1-128). Special education and related services shall be provided through TDMHMR schools at the RMHI. TDMHMR schools operate under 34 CFR §300.2 as "other State agencies and schools" and as such, must meet the *Rules, Regulations, and Minimum Standards for the Governance of Tennessee Public Schools* established by DOE. *See Article 4 Section A - DOE.*

3. As mandated by federal and state law and regulation, DOE will monitor all IDEA programs and services provided by RMHI using an appropriate monitoring instrument. *See Article 4 Section A - DOE.* DOE, in conjunction with TDMHMR, shall provide technical assistance regarding IDEA requirements and special education and related services to RMHI staff and teachers, as appropriate. DOE through its monitoring, in conjunction with TDMHMR and the RMHI staff, shall identify training and technical assistance needs at the RMHIs.

4. When a child who is IDEA eligible resides in a RMHI and is receiving inpatient services, the RMHI school will continue to follow the child's IEP from the previous educational placement until the child is discharged. However, the child's IEP shall be reviewed and modified as appropriate and consistently with IDEA. If the child who is IDEA eligible is residing in the RMHI and does not have an IEP, the RMHI school shall convene an IEP Team meeting in order to determine IDEA eligibility and develop an IEP if appropriate.

5. In order to expedite the provision of special education and related services to any child who is IDEA eligible living in a RMHI, the LEA formerly serving the child shall provide the RMHI with the child's education records within fourteen (14) calendar days of receipt of the request unless there is a critical need to expedite forwarding the records. With the consent of the child's parent, TDMHMR will notify the local LEA that an IDEA eligible child is being released from

a. The local LEA where the detention center is located shall serve as the LEA for a child who is IDEA eligible living there.

b. The local LEA shall convene an IEP Team meeting to determine eligibility and develop an IEP for a child who is IDEA eligible, if appropriate. The local LEA shall provide the detention center with teachers who shall provide the educational program to the child with a disability in the detention center in accordance with the child's IEP. The LEA shall assume the financial responsibility for the provision of special education and related services.

c. The financial responsibility of other Participating Agencies to provide services in the child's IEP shall not be altered because the IDEA eligible child is being educated in a detention center except that children who are incarcerated are not eligible for TennCare services. [The issue is being reviewed by the Attorney General's Office and may change before the Agreement is sent to the Commissioners.]

10. The obligation to make FAPE available to all children with disabilities does not apply to students age eighteen (18) to twenty-one (21) if, prior to incarceration in an adult correctional facility, the students were not actually identified as being IDEA eligible and did not have an IEP. If a child with a disability is convicted as an adult under state law and incarcerated in an adult prison, the following requirements of IDEA do not apply: 1) the requirements contained in 34 CFR §300.138 and §300.347(a)(5)(i) (relating to participation of children with disabilities in general assessments; and 2) the requirements of §300.347(b) (relating to transition planning and transition services) with respect to students whose eligibility under Part B will end because of their age before they will be eligible to be released from prison considering their sentence and possibility for early release. The IEP Team of a student with a disability who is convicted as an adult and incarcerated in an adult prison may modify the student's IEP or placement if the state has demonstrated a bona fide security or compelling penological interest that cannot otherwise be accommodated. The IDEA requirements relating to the least restrictive environment do not apply to the modification of placement for penological reasons. *34 CFR §300.311.*

11. In order to expedite the provision of special education and related services to any child who is IDEA eligible in DCS custody, a LEA formerly serving the child shall provide DCS with the child's education records within fourteen (14) calendar days of receipt of the request unless there is a critical need to expedite forwarding of the records. The former LEA providing the child's special education and related services should forward to DCS the child's IEP and all evaluations which were used to assess the child's IDEA eligibility. However, failure to receive education records does not suspend the responsibility of DCS to provide a child with a disability FAPE in the least restrictive environment. Nothing in this provision is meant to supersede the requirements of FERPA, state and federal law and the regulations promulgated thereunder.

12. When it appears that a child who is IDEA eligible in DCS custody can be provided FAPE in a less restrictive environment, DCS shall facilitate the child's transition to the LEA in the following manner:

a. DCS shall notify the LEA of the need to convene an IEP Team meeting. DCS and the LEA will work together to determine an appropriate placement. A representative from DCS shall attend an IEP Team meeting to assist in determining the most appropriate educational placement. However, the DCS representative shall not sign the IEP as parent.

b. Educational programs provided to children in DCS contract facilities shall be monitored by DOE. The Department of Finance and Administration shall monitor compliance with the contract provisions, and DCS shall provide the facility with technical assistance as necessary. Before entering into a contract with any facility that will provide educational programs to children in DCS custody, DCS will assure DOE that the facility will meet the standards enumerated in *Rules, Regulations and Minimum Standards for the Governance of Tennessee Public Schools* for non-public schools. DCS shall not contract with a facility for the provision of special education and related services for a child who is IDEA eligible in state custody who has DOE category five school approval.

c. The financial responsibility of other Participating Agencies to provide services in the child's IEP shall not be altered because the child who is IDEA eligible is being educated in a contract facility.

5. The provision and cost of special education and related services for a child with a disability in DCS custody, living in a contract facility that does not maintain an on-site school shall be provided for in the following manner:

a. The local LEA where the child is residing shall have primary responsibility for fulfilling the requirements of IDEA. *See Article 4, Section B - LEA.*

b. DCS shall refer the child to the local LEA which will evaluate the child for IDEA eligibility. The local LEA shall convene an IEP Team meeting to determine eligibility and develop and implement an IEP if appropriate.

c. A DCS representative (which may include a DCS contract agency representative) shall be present at the IEP Team meeting of all children who are IDEA eligible in DCS custody. However, the DCS representative may not sign the IEP, as a parent. The parent must sign the IEP. If a parent cannot be located, the LEA will appoint a surrogate parent. The surrogate parent, when representing the child's educational interests, shall have the same rights as parents of IDEA eligible children.

6. The provision and cost of special education and related services for a child with a disability in DCS custody and living in a runaway house/shelter shall be provided for in the following manner:

a. Runaway houses/shelters have entered into a contract with DCS and are considered contract facilities with the same educational responsibilities as any other DCS contract facility. *See Article 4 Section D4.*

b. The runaway house/shelter shall convene an IEP Team meeting to determine eligibility and to develop and implement an IEP, if appropriate. The runaway house/shelter shall assume the costs of providing special education and related services as indicated in the IEP.

c. The financial responsibility of other Participating Agencies to provide services in the child's IEP shall not be altered because the child who is IDEA eligible is being educated in a runaway house/shelter.

schools if these services can be delivered by the MCOs' or BHOs' qualified providers within the required access standards.

Children who are incarcerated in a detention center or other secure public institution are considered inmates and are not covered by TennCare. *42 CFR §435.1008, 435.1009.* [The issue is being reviewed by the Attorney General's Office and may change before the Agreement is sent to the Commissioners.]

Emergency medical services are available twenty-four (24) hours per day, seven (7) days per week for TennCare enrollees. Coverage of emergency medical services is not subject to prior authorization by the MCO. *Tenn.Rule 1200-13-12-.04(4)*

Each TennCare MCO and BHO is responsible for the management of medical care and continuity of care for all its TennCare enrollees including children who are IDEA eligible. Specific responsibilities include performance of reasonable preventive health case management services, appropriate referral and scheduling assistance for enrollees needing specialty health care services, monitoring of enrollees with ongoing medical conditions, coordinated hospital and/or institutional discharge planning that includes post-discharge care as appropriate, maintenance of an internal tracking system which identifies the current preventive service screening status and pending due dates for each enrollee, and authorization of out-of -plan or out-of-state services which are medically necessary due to an emergency. *Contractor's Risk Agreement between TennCare and MCO September, 1995.* In addition, to coordinate EPSDT screens and services, each TennCare MCO/BHO shall provide case management services by assisting children for whom case management is medically necessary. *John B. Consent Decree at p. 38.* The case management provided shall center on the process of collecting information on the health needs of the child, making and following up on referrals as necessary, and activating the examination/diagnosis/treatment loop. *Id. at pp. 38-9.* The case management services must meet the needs of the child and cannot be used exclusively as a tool for prior authorization. *Id. at p. 39.*

TennCare shall coordinate the delivery of covered health and behavioral health services with services offered by other state health agencies and shall attempt to make use of other public health, mental health, and educational programs and related programs such as Head Start to ensure an effective child health program. TennCare shall inform the LEAs that MCOs are responsible for requesting the IEPs of enrollees who they know are children who are IDEA eligible and enrolled in each MCO. TennCare has developed a release form to provide to LEAs that a parent may use to consent to the release of education records consistent with IDEA, FERPA and all applicable state and federal regulations. The LEA is responsible for sharing the IEP with the PCP after obtaining appropriate parental consent. *See Attachment 3 - TennCare Release Form.* **MCOs shall accept the IEP indication of a medical problem or shall have the child appropriately tested.** Coordination by the MCO and LEA should be calculated to reduce gaps and overlaps in services. *John B. Consent Decree p. 42.*

The Solutions Unit, as designated by TennCare, will review all TennCare appeals by TennCare enrollees regarding the denial, delay, termination, suspension, or reduction of medical assistance by the MCO or BHO. Appeals will be handled in accordance with procedures outlined in applicable State rules and as required by the *Grier* revised Consent Decree. *TennRule 1200-13-12-.11.*

financial responsibility for covering that service pursuant to appli regulations and this Agreement. The LEA shall also send the pub that pertains to the services in question. The LEA shall notify all financial responsibility for special education and related services meeting by sending a copy of the invitation sent to the parents o *§300.344*. The public agency that has financial responsibility for IDEA eligible with services shall not be relieved of that responsit agency representative does not attend an IEP Team meeting. Ad public agency to pay for that service shall not relieve the LEA of service to the child with a disability in a timely manner. *34 CFR* may seek reimbursement for the services for which the child is eli programs from the public agency that failed to provide or pay for for a LEA to seek reimbursement from TennCare or a MCO or BI TennCare provider. If there is a dispute regarding reimbursement in accord with the procedures outlined in Article 6 of this Agreem

11. The LEA shall provide information to the parent of a child who is services from other public agencies that may assist the parent in n which are not services under IDEA. If the school suspects that nc suspected disability have been addressed, it is the school's respon and contact other Participating Agencies, as necessary, unless the referral by the LEA representative on the IEP Team of a child to (be considered a determination of eligibility or obligate the public any service not in the child's IEP. The parent shall be responsibl requirements of other public agencies.

12. Beginning one year before a student reaches the age of majority ((the student's IEP must include a statement that the student has be under IDEA that will transfer to the student upon reaching the age be transferred from the parent to the student upon reaching the ag student has been declared incompetent under Tennessee law. *34* nothing in this section prohibits the LEA from inviting a child's p if the parent has special knowledge related to the student which m appropriate special education and related services for the student majority. *34 CFR §300.344(a)(6).*

C. Bureau of TennCare

1. TennCare contracts with MCOs to provide medical care through r health providers. MCOs are paired with BHOs to create access to enrollees in need of mental health and substance abuse services. and BHOs to ensure that they are in compliance with TennCare R accessible in-network providers to TennCare enrollees.

2. TennCare shall perform TennCare eligibility determinations for c TennCare and conduct EPSDT outreach to help TennCare enrolle necessary care consistent with *John B.* Consent Decree at pp. 15-

services from any other Participating Agency. All information provided by the parents of a child who is IDEA eligible is voluntary and will be used only to ensure compliance with IDEA. IDEA services provided by the LEA to children who are IDEA eligible will not be reduced nor will IDEA eligibility be affected if the child is enrolled in the TennCare program. TennCare may not disqualify a medically necessary covered service for reimbursement because that service is provided in accordance with an IEP. *34 CFR §300.142(b)(1)(i).* Individual TennCare information such as MCO, BHO, PCP, and related medical information shall be kept strictly confidential as required by FERPA, IDEA, and all applicable state and federal law. Such information will only be used by the LEA to coordinate the appropriate special education, related services, and medically necessary services for each IDEA and TennCare enrolled child. All records and information shall only be disclosed to the extent allowed by IDEA, FERPA, and all other applicable state and federal laws. *See Article 7 - Records.* When a child identified as IDEA eligible is also a TennCare enrollee, the LEA will ask the parent to notify the child's PCP and MCO that the child is receiving special education and has an IEP. The LEA shall also request that the parent agree to share the child's IEP with his/her PCP and MCO. TennCare has developed a release form to help facilitate the disclosure of the IEP to the PCP so that they can help these children receive medically necessary TennCare services, if appropriate. *See Attachment 3 - TennCare Release Form.*

3. In order to ensure that FAPE is provided to eligible children at no cost to parents, parents shall not be required to use private insurance to pay for special education and related services. *34 CFR §300.142(f).* The use of private insurance must be voluntary and the parents must consent. If a parent elects to access private insurance, the LEA may pay the family's copayment assessed by the insurance company using Part B funds.

4. Services and evaluations for children who are IDEA eligible must be provided within a reasonable time period. *34 CFR §300.142(b)(2).* In order to provide special education and related services in a timely and efficient manner to students who are IDEA eligible, a LEA may contract with appropriate providers or provide the needed services itself. If the child is a TennCare enrollee, the MCO shall accept the IEP indication of a medical problem or shall have the child appropriately tested. *John B* Consent Decree *at p. 42.* TennCare will provide all medically necessary covered medical services and all EPSDT screens and interperiodic screens that the child may need. If the child is a TennCare enrollee and non-emergency medical services are provided by the LEA, the LEA must be a TennCare provider in order to seek reimbursement for these services from TennCare consistent with policies and procedures adopted by TennCare, DOE, and this Agreement.

5. Once a child is evaluated, the LEA will convene an IEP Team meeting to determine if the child is eligible to receive special education and related services. If eligibility is determined, the IEP Team will create an appropriate IEP. The special education teacher or person responsible for facilitating the IEP Team meeting will send an invitation to the child's parents and will send a copy of the invitation or personally call representatives from other agencies to participate in the IEP Team meeting if the other agencies may be required to provide services listed in a child's IEP. The LEA will provide all special education or related services to children with disabilities that are part of the IEP and necessary for FAPE in the least restrictive environment. *34 CFR §300.343*

6. All LEAs and Participating Agencies that have chosen to provide special education and related services to IDEA eligible children in contract facilities within the State of Tennessee must ensure the facility meets the requirements set forth in *Rules, Regulations, and Minimum*

6. DOE shall ensure that all due process hearings requested by parents to resolve issues of IDEA eligibility, placement, or the provision of FAPE will be conducted in accordance with all applicable state and federal statutes and regulations. DOE will maintain a list of state hearing officers and their qualifications. DOE shall appoint hearing officers. All due process hearings under IDEA shall be conducted consistently with state and federal law. *TCA §49-10-601.*

7. In accordance with IDEA, DOE will investigate all administrative complaints filed by parties as it relates to compliance and provision of special education and related services for children who are IDEA eligible. Within sixty (60) calendar days of receipt of a complaint, DOE will conduct an independent investigation; give the complainant an opportunity to submit additional information; and make an independent determination of the issue. DOE will issue a written decision that addresses each of the complainant's allegations and contains findings of fact and conclusions of law as well as the reasons for its final decision. When appropriate, DOE shall conduct on-site investigations to gather additional data and resolve complaints. Upon request and as deemed necessary by DOE, DOE will grant extension to sixty (60) calendar days for the resolution of the complaint in order for the parties to submit additional information. *34 CFR §300.661.*

8. Upon request and with the consent of both the parent and the LEA, DOE will assign a mediator to resolve disputes arising under IDEA. DOE will appoint mediators and provide them with training in mediation and special education law. Consent to mediation by the parent of a child who is IDEA eligible is voluntary and will not delay or deny a parent's right to a due process hearing nor shall it deny parents any other rights afforded them under IDEA Part B. DOE shall bear the cost of the mediation process. Consistent with IDEA, all discussions that occur during the mediation process must be confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings. The parties to the mediation process are required to sign a confidentiality pledge prior to the commencement of the process. *34 CFR §300.506.*

9. DOE shall administer the Systems Change Transition Grant. To receive this grant, the LEA must submit an application to DOE with a proposal for transition services to be provided by the LEA. If accepted, DOE will furnish the LEA with funds to implement the Transition Services proposed in the application. Transition specialists from DOE shall monitor the programs and provide the LEAs with technical assistance as needed. Transition specialists will provide these services to LEAs who are receiving grant funds as well as those that are not. The Systems Change Transition Grant is a one time one year grant to provide seed money for transition services. After the one year grant ends, the Transition Program should be sustainable by the LEA.

10. DOE encourages LEAs to participate in the School to Work Case Manager's Grant Program administered by DHS/DRS. This grant provides the LEA with federal funding to employ a transition case manager to work with DHS/DRS eligible students in the LEA. The LEA is required to provide state or local match dollars. *See Article 4 Section G - DHS/DRS.*

11. DOE has developed a departmental policy which allows for the reimbursement of the LEA for sixty to one hundred percent (60%-100%) of the cost for services provided to high cost/medically fragile children based on the availability of federal funds within any given fiscal year. Criteria established by DOE will be used to determine the priority of disbursement of funds. To apply for these funds, the LEA shall file a request with DOE for reimbursement. The request shall be reviewed by the Assistant Commissioner of the Division of Special Education or his/her designee. The funds shall be distributed to the LEA based on special

identification, evaluation, and educational/early intervention placement of the child; and (b) the provision of FAPE/early intervention services to the child. *34 C.F.R. § 300.515(a) & (e).*

51. **"TennCare"** is the program by which the State of Tennessee provides medical assistance to persons eligible for Title XIX of the Social Security Act (Medicaid), to uninsured children under the age of nineteen (19), and to uninsured persons of any age who have been denied health insurance because of a health problem. References to TennCare shall also include reference to the Bureau of TennCare, TennCare Partners, and any other agencies, public or private, contractors and subcontractors through whom TennCare provides medical benefits. *Tenn. Rules 1200-13-12-.01(3) & .02(a).*

52. **"TennCare enrollee"** means any TennCare eligible person who has enrolled in a MCO authorized to provide services in the geographical area where the person resides. Persons enrolled in TennCare are automatically enrolled in the TennCare Partners Program and will be served by the BHO partnered with the MCO in which the person has enrolled. *Tenn. Rules 1200-13-12-.01(13) & 1200-13-12-.02(8)*

53. **"TennCare provider"** means an institution, facility, agency, person, corporation, partnership, or association which accepts, as payment in full for providing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with a managed care organization. Such payment may include fees, deductibles, copayments, special fees or any combination of these. *Tenn. Rules 1200-13-12-.01(28).*

54. **"Tennessee Early Intervention System"** (TEIS) means a network of nine district offices established by DOE that provides access under IDEA Part C to early intervention services statewide. TEIS offers a wide range of services from which an individualized program can be designed to meet the unique needs of each child and family.

55. **"Transition services"** for IDEA Part B, means a coordinated set of activities for a student, designed within an outcome-oriented process, which promotes movement from school to post-school activities, including postsecondary education, vocational training, integrated employment including supported employment, continuing education, adult education, adult services, independent living, and community participation. *34 CFR §300.29 & Rehabilitation Act of 1973 as amended, §7(37).*

56. **"Vocational rehabilitation services"** means any services described in an individualized plan for employment necessary to assist an individual with a disability in preparing for, securing, retaining, or regaining an employment outcome that is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual. *Rehabilitation Act of 1973 as amended, §103.*

57. **"Youth Development Center"** means a secure facility, operated by DCS, for those who have been adjudicated delinquent and meet the criteria established by DCS for placement at such facility. *TCA §37-5-103(16).*

(d) The most appropriate supply or level of services that can safely be provided to the person.

When applied to the care of an inpatient, it further means that services for the person's medical symptoms or condition require that the services cannot be safely provided to the person as an outpatient. *Tenn. Rule 1200-13-12-.01(25).*

35. **"Natural environments"** for IDEA Part C purposes, mean settings that are natural or normal for a child's age peers who have no disability. *34 CFR §303.12(b)(2).*

36. **"Parent,"** for IDEA purposes, means—

(a) A natural or adoptive parent of a child;

(b) A guardian but not the State if the child is a ward of the state;

(c) A person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare); or

(d) A surrogate parent who has been appointed in accordance with 34 C.F.R. § 300.515 (Surrogate Parents). *34 CFR §300.20(a).*

A foster parent may act as a parent if—

(a)The natural parent's authority to make educational decisions on the child's behalf has been extinguished under Tennessee law; and

(b) The foster parent--

(i) Has an ongoing, long-term parental relationship with the child;

(ii) Is willing to make the educational decisions required of parents under the IDEA; and

(iii) Has no interest that would conflict with the interests of the child.

34 CFR §300.20(b).

37. **"Participating Agencies"** means the Tennessee Department of Children's Services, the Tennessee Department of Education, the Tennessee Department of Finance and Administration, the Tennessee Department of Health (Part C only), the Bureau of TennCare, the Tennessee Department of Human Services/Division of Rehabilitation Services (Part B only), the Tennessee Division of Mental Retardation Services, and the Tennessee Department of Mental Health and Mental Retardation.

38. **"Payor of last resort"** means the agency that has ultimate responsibility for providing a service for a child with a disability or his family after all other potential resources have been exhausted.

39. **"Permanency planning"** means the process of intervention and decisive casework on the part of the DCS case manager. Such intervention focuses on choosing the least restrictive permanent outcome for the child, i.e. return to parent, relative placement, adoption, independent living or permanent foster care, in a timely manner. *DCS Glossary p. 23.*

40. **"Personally identifiable information"** means the information that relates to or concerns an individual student. It includes but is not limited to the student's name, the name of the student's parent(s) or other family member(s), the address of the student or student's family, a personal identifier such as the student's social security number or student number, and a list of personal characteristics that would make the student's identity easily traceable. *34 CFR §300.500(b)(3).*

19. **"ICC"** means the State Interagency Coordinating Council under IDEA Part C. *34 CFR §303.600.*

20. **"Individuals with Disabilities Education Act"** (IDEA) means the collective name for federal legislation codified at 20 USC §1400 *et seq.* as amended, providing federal funds for special education and related services and early intervention services to children with disabilities in accordance with standards set by the Act.

21. **"Individualized Education Program"** (IEP) means a written statement that is developed, reviewed, and revised in a meeting of the IEP Team, in accordance with 34 C.F.R. §§ 300.341-300.350 (IEP), for a child with a disability who qualifies for special education and related services under IDEA Part B.

22. **"Individualized Education Program Team"** (IEP Team) means a statutorily defined group of individuals under 34 C.F.R. § 300.344 (IEP Team), with the responsibility for determining eligibility and/or special education and related services under IDEA Part B.

23. **"Individualized Family Service Plan"** (IFSP) means a written plan for providing early intervention and other services to an eligible child and the child's family under IDEA Part C which:

(a) Is developed jointly by the family and appropriate qualified personnel involved in the provision of early intervention services;
(b) Is based on the multidisciplinary evaluation and assessment of the child and the assessment of the child's family;
(c) Includes services necessary to enhance the development of the child and the capacity of the family to meet the special needs of the child;
(d) Contains a statement of the natural environment in which early intervention services shall appropriately be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environment; and
(e) Is reviewed by interactive means acceptable to all parties, and at least on a six month interval. *34 CFR §303.340(b) & 303.344.*

24. **"Individual Support Plan"** (ISP) means a written document central for planning, providing and reviewing the supports and services to be provided by DMRS through its contract agencies for those in the HCBS waiver. *DMRS's Family Handbook p. 30.*

25. **"Infant or Toddler with a Disability"** means an individual birth to age three who qualifies for early intervention services under IDEA Part C because he/she:

(a) Is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development; physical development, including vision and hearing; communicative development; social or emotional development; adaptive development; or
(b) Has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay; or
(c) Exhibits developmental delays for which there are no standardized measures or for which existing standardized procedures are not appropriate for the child's age or a given developmental area.

This child may, in accordance with procedures established by DOE, be deemed eligible by an Informed Clinical Opinion. *34 CFR §303.16.*

attending private schools; underserved populations such as children in rural and urban areas; and highly mobile children with disabilities (e.g. migrant and homeless children) residing in Tennessee, regardless of the severity of their disability, and who are in need of early intervention services or special education and related services, are identified, located, and evaluated. Child Find includes the process developed and implemented to determine which children are currently receiving early intervention services or special education and related services. *34 CFR §300.125 & 303.321.*

4. **"Child with a disability"** for IDEA purposes, means a child evaluated as having mental retardation, a hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, an emotional disturbance, an orthopedic impairment, autism, traumatic brain injury, other health impairment, specific learning disability, deaf-blindness, or multiple disabilities consistent with IDEA and in need of special education and related services. *34 CFR §300.7(a).*

5. **"Contract facility"** for DCS purposes, means a facility that contracts with the State to provide treatment and/or residential services to children in DCS custody. *DCS Glossary p. 7.*

6. **"Custody"** means the control of actual physical care of the child and includes the right and responsibility to provide for the physical, mental, and moral well-being of the child. *TCA §37-1-102(b)(8).* For DCS purposes, children in state custody who have been placed in a permanent setting (i.e. birth, adoptive, relative, or other permanent home) but whose legal custody has not been transferred to a permanent guardian or custodian are in legal but not physical custody of DCS. A child is in DCS physical custody when the child is in state custody and DCS is providing for the child's residential needs.

7. **"Detention center"** means a place of confinement for juveniles in a secure or closed type of facility which is under the direction or supervision of the court or a facility which is designated by the court or other authority as a place of confinement for juveniles. *TCA §37-1-102(13).*

8. **"Developmental center"** means a facility certified by the Department of Health or the Department of Mental Health and Mental Retardation as an ICF-MR, which may be further defined in TCA Title 33.

9. **"Early intervention system"** means the total effort in Tennessee that is directed at meeting the needs of children eligible under IDEA Part C and their families. *34 CFR §303.11.*

10. **"Early Periodic Screening, Diagnosis and Treatment"** (EPSDT) means screening in accordance with professional standards, interperiodic screening, and diagnostic services to determine the existence of physical or mental illness or conditions in recipients under age 21; and health care, treatment, and other measures described in 42 USC §1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered. *Tenn.Rule 1200-13-12-.01(38).*

11. **"Education records"** mean those records, files, documents, and other materials which contain information directly related to a student and are maintained in an educational agency or institution or by a person acting for such agency or institution which are not specifically excluded under the five categories of exceptions set out in 20 USC §1232g(a)(4)(B) (FERPA - Exceptions).

INTERAGENCY AGREEMENT

AMONG

TENNESSEE DEPARTMENT OF EDUCATION,

TENNESSEE DEPARTMENT OF CHILDREN'S SERVICES

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION,

TENNESSEE DEPARTMENT OF HEALTH,

TENNESSEE DEPARTMENT OF HUMAN SERVICES,

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION,

and

TENNESSEE DIVISION OF MENTAL RETARDATION SERVICES

June 12, 2000

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- The Steering Panel has been appointed and has met once. Four subcommittees are being organized or have already met dealing with:
  - Best Practice Networks,
  - Best Practice Guidelines for both physical and behavioral health care,
  - Needs Assessment, and
  - Data
- In-house work groups have been meeting to address administrative and data issues.
- Numerous discussions have been held with Centers of Excellence to pinpoint specific responsibilities regarding contractual obligations.
- Local pediatric groups are reviewing the plan to address issues regarding provider participation.
- An article outlining the EPSDT Remedial Plan has been drafted for submission to the Tennessee Medical Association Journal. The article is expected to be published within the next couple of months.

6. **Services testing on a sample of plaintiff class members.** *(Paragraph 99)* East Tennessee State University (ETSU) was chosen to conduct an analysis of a random sample of the TennCare population of children and adolescents to determine whether they have received necessary diagnoses and medical/behavioral treatment in conformity with the requirements of the Consent Decree. A draft of the study entitled "An Evaluation of Health Care Services in the Pediatric TennCare Population" was submitted to the Bureau of TennCare in January 2000. The final report can be found in Attachment L. The study included an analysis of information from telephone interviews from 650 adult family members and other collateral resources. Medical experts reviewed the records of 503 children from the targeted year, 1998. Results of the study include:

- Almost 100% of the children in the study received regular check-ups. Approximately 95% of the check-ups were received from a Primary Care Provider (PCP), while 5% were received from a Public Health Department (5%).

- The medical record review revealed a specialist referral rate of 5.4% for all diagnostic/treatment episodes. In 89% of the medical records reviewed there was no difficulty in obtaining specialist referrals.

- Of the more than 3,000 diagnostic and treatment events recorded in the medical records, 92% of recorded treatments were judged to be appropriate and 3% as inappropriate.

- 90% of the parents were satisfied with the care provided by their child's PCP, 84% with the care received at the Public Health Department, 86% with specialist care, and 92% with dental care.

4. **Enhanced monitoring of discharge planning for psychiatric and chemical dependency facilities**. *(Paragraph 71iii)* The Quality Oversight Division in conjunction with a representative from Premier/TBH continues to conduct medical record reviews at psychiatric inpatient facilities and residential treatment facilities (RTFs). The purpose of the review is to determine if there is collaboration, coordination and continuity of care in all aspects of the discharge planning process.

Seven medical record reviews were conducted during February 2000 through June 2000 in Knoxville, Johnson City and Nashville. Consumers under the age of twenty-one were reviewed at each location. The lack of documentation of follow up appointments, evaluation of transportation needs, appropriate documentation in the medical record that identifies problems requiring follow up, and securing appropriately signed releases in order to forward information to outside providers are examples of the deficiencies identified during the discharge planning audit.

The Quality Oversight Division requested a plan of correction from each site to address improvements for consumers under the age of twenty-one. Plans of correction have been received and accepted.

The Quality Oversight Division also continues to monitor case management through monthly reports received from the BHOs regarding the number of patients who have been discharged from a psychiatric inpatient facility/RTF. A subset analysis is performed on the data of the monthly Case Management Report for consumers under the age of twenty-one. TennCare utilizes this information to evaluate case management provided to consumers and to identify any areas of concern that may require follow-up.

The reports received from the BHOs reflect an increase in reported face to face case management encounters occurring seven days prior to seven days post discharge from an inpatient psychiatric/RTF (See Attachment H.) Most notably, the percentage of consumers who accepted the offer of a referral for case management and received a case management encounter has risen to an average of 85% during the last three month period (February through April 2000), from a July through September 1999 average of 72%.

As a result of performing the subset analysis, the Quality Oversight Unit identified a group of consumers (under the age of twenty-one) who were discharged from inpatient psychiatric facilities/ RTFs and who accepted the offer for a referral for case management but did not receive an encounter. The Quality Oversight Unit requested a plan of correction that identified barriers that prevented this group from receiving a case management encounter. The barriers identified and proposed interventions that would assure that consumers under the age of twenty-one who accepted a referral for case management would receive the service can be found in Attachment I.

The EPSDT Screening Guidelines Committee finalized the vision and hearing guidelines January 1999, and the behavioral and developmental screening guidelines September 1999, as required by the EPSDT Consent Decree. Dr. Michael Myszka, Director of Psychology Services for the Bureau of TennCare, and Joseph McLaughlin, Ph.D., Chair of the EPSDT Screening Guidelines Committee completed an introduction to the recommended guidelines. The introduction defines the purpose of the Committee, technical criteria and research studies used in the selection of screening instruments and the authority of the Consent Decree. A copy of the introduction and the hearing and vision and behavioral and developmental screening guidelines can be found in Attachment B.

Dr. Michael Myszka has also written and submitted articles about EPSDT requirements and the recommended screening guidelines (See Attachment C.) to the Tennessee Academy of Family Physicians and the Pediatric Society of Tennessee for publication in their professional journals. Both articles have been accepted and we are waiting to receive a notice of publication. Dr. Myszka is currently working with another committee member on completing an article for submission to the Tennessee Nursing Association.

The arrangements for statewide training on the EPSDT screening guidelines have been finalized. TennCare providers or representatives from their offices are being requested to attend training sessions on the screening guidelines recommended by the EPSDT Screening Guidelines Committee. Each session is scheduled from 9:00 a.m. until 3:00 p.m. and former members of the EPSDT Screening Guidelines Committee will be conducting the training. See Attachment D for dates, locations and a tentative agenda for the workshops.

2. **Annual medical record review**. *(Paragraph 46)* The annual medical record review has been completed for a sample of 2,200 children from birth through five years of age. The results are being analyzed and the final report is due by the end of September 2000.

The EPSDT screening percentage reported on the Health Care Financing Administration (HCFA) 416 report for Federal Fiscal Year (FFY) 1999 was 36%. The adjusted periodic screening percentage (APSP) for FFY 99 is 19.8%. This figure is calculated by multiplying the screening percentage reported on the HCFA 416 report by the percentage of required components included in EPSDT screens reported in the annual medical record review.

The dental screening percentage (DSP) is calculated by dividing the actual number of dental encounters provided for children aged 3-20 by the expected number of encounters for children in this age group. The DSP for FFY 99 is 28.5%. A summary of the EPSDT benchmarks and the FFY 99 HCFA 416 report can be found in Attachment E.

Overview

Efforts to ensure compliance with the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) Consent Decree as well as to increase public awareness of EPSDT services are ongoing. The Bureau of TennCare and the Department of Children's Services (DCS) are committed to improving the delivery of EPSDT services to their consumers. An overview of the State's progress for the period of January 1, 2000, through July 31, 2000, is contained in this semi-annual progress report.

During the past six months several activities occurred that were not specifically required by the EPSDT Consent Decree but nevertheless will have an impact on the issues identified in the Consent Decree. These activities include the following:

- **Early Child Health Outreach (ECHO)**. The Tennessee Health Care Campaign (THCC) received a three-year grant in November 1999, from the Nathan Cummings Foundation to begin a new program called ECHO. The ECHO program is focused on outreach and education to parents of TennCare-eligible children from birth to six years old. ECHO educates parents about their right to EPSDT services and their right to file a medical appeal if services are denied, delayed or terminated by the managed care organization (MCO) or the behavioral health organization (BHO). The THCC is subcontracting with six other organizations to perform media activities, training seminars and outreach activities including special outreach efforts for Hispanic families. A twelve minute instructional video has been completed that provides information on how to enroll in TennCare, EPSDT services, grievance and appeal rights and important numbers to call when assistance is needed in accessing EPSDT services. There are English and Spanish versions of the videotape and it can be ordered from the THCC.

- **TennCare for Children Project**. The THCC also directs the TennCare for Children Project which is a program designed to develop social marketing strategies focusing on increasing TennCare enrollment of children, maintaining enrollment, and encouraging the use of TennCare services, including EPSDT services. The ECHO program and the TennCare for Children Project complement one another.

- **TennCare Shelter Enrollment Project**. The National Health Care for the Homeless Council (NHCHC) administers the TennCare Shelter Enrollment Project. This program is currently the only source of direct training and technical support available in the state to facilitate TennCare enrollment of homeless children. For the 1999-2000 fiscal year, the Shelter Project expanded its TennCare enrollment and outreach training to focus on strategies that educate and inform homeless parents about the availability of EPSDT services as well as how to access these services for their children. To accomplish this task, the project coordinator planned and organized regional EPSDT outreach and enrollment workshops in the three grand divisions of the state. As a result of the regional training sessions, a total of 110 emergency shelter providers and child advocates were informed about how to enroll homeless children in TennCare and how to facilitate their access to EPSDT services. The

Semi-annual Progress Report

EPSDT Consent Decree

July 2000